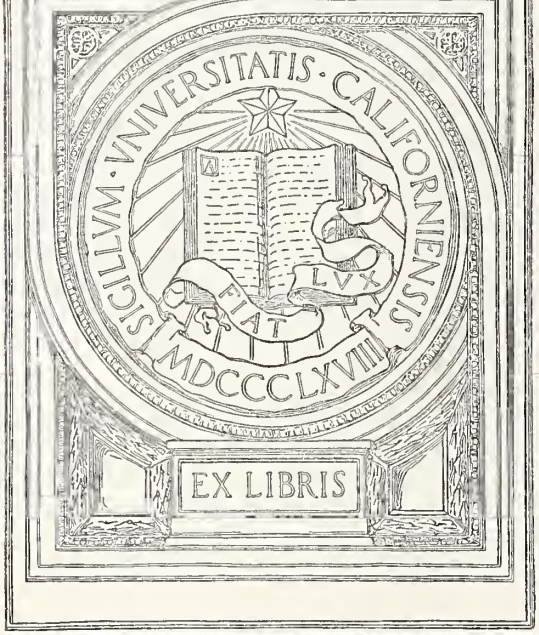
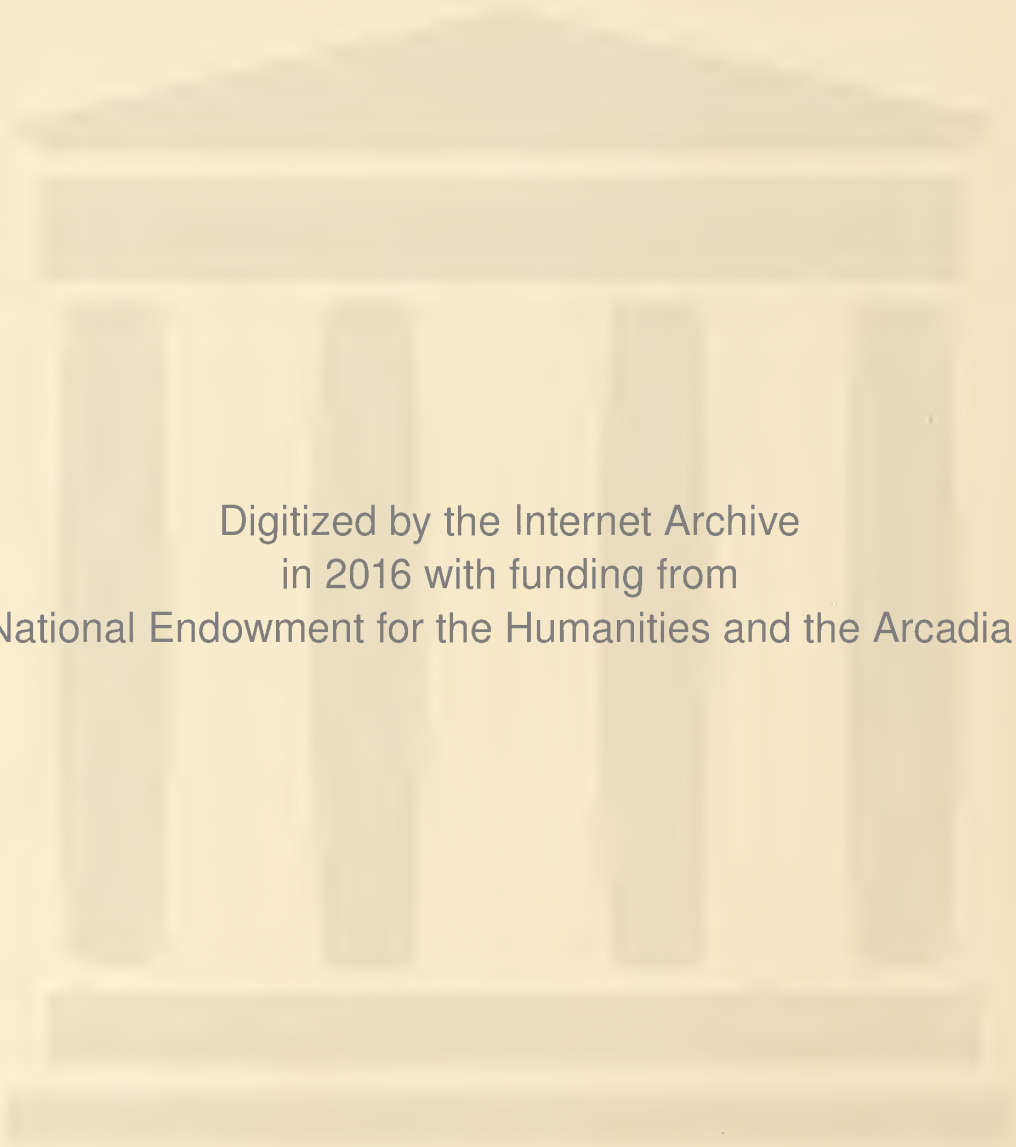
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# Preoperative Calm

ALTHOUGH many of the derivatives of barbituric acid have a generic resemblance in their principal action, there are significant differences which establish certain compounds in special clinical fields. For example, 'Sodium Amytal' (Sodium Iso-amyl Ethyl Barbiturate, Lilly), while frequently prescribed for insomnia, has been found particularly useful as a preanesthetic hypnotic. Given preoperatively it serves to allay fear and apprehension, improves the patient's mental attitude, thus facilitating surgical procedure. 'Sodium Amytal' is also widely employed in obstetrics. In recommended dosage it is capable of producing amnesia without prolonging dilatation of the cervix or interfering with the strength or frequency of uterine contractions.

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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. IX JANUARY, 1945 No. 1

# RECENT ADVANCES IN THE TREATMENT OF HEART DISEASE

LOUIS H. NAHUM, M.D., and SIMON D. DOFF, M.D., *New Haven*

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JOHN BUNYAN, almost three centuries ago, wrote, "Physicians get neither name nor fame by pricking of wheals or picking out thistles or by laying of plasters to the scratch of a pin; every old woman can do this. But if they would have a name and a fame, if they will have it quickly they must do some great and desperate cures. Let them fetch one to life that was dead; let them recover one that was born blind to see or let them give ripe wits to a fool. These are notable cures and he that can do them, if he does them first he shall have the name and fame he deserves, he may lie abed until noon."

## I. CONTRIBUTIONS OF SURGERY

### A. PATENT DUCTUS ARTERIOSUS

*Pathologic Physiology*—The successful closure of the patent ductus arteriosus by Gross and Hubbard[1] was followed by a study of the pathologic physiology in humans,[2,4] and in animals with experimental patent ductus[2,3] by new methods. In individuals without endocarditis, the flow of blood was found to occur only from the aorta into the pulmonary artery. This shunted an unusual amount of blood into the lungs, reduced the vital capacity and prolonged the circulation time significantly. Because of the increased venous return to the left ventricle, its output was greatly increased amounting in most cases to from two to four times the normal. It is this extra burden on the left ventricle which in time leads to cardiac failure and venous engorgement. The increased pulse pressure in many cases is explained by the dynamics of the circulatory fault. The increased left ventricular output increases the systolic pressure while the aortic pulmonary communication tends to lower the diastolic pressure to a variable point approaching the diastolic pressure in the pulmonary artery. Comparable experiments in dogs showed similar results, but there was no change in mean blood pressure.[3] In man, the pulse pressure is wide due mainly to a low diastolic pressure.[2] Following closure of the patent ductus, there is an increase in the diastolic blood pressure, the circulation time becomes normal and the cardiac dilatation disappears.

Important deductions concerning the pathologic physiology have come out of observations made before and after the operation on the cases with subacute bacterial endarteritis.[5,6] Reverse eddy currents may carry a certain amount of infected material into the aorta. This is most likely to be possible when the ductus is short. In favor of this assumption are repeated observations concerning the amazing rapidity with which the peripheral blood culture become negative following operation in certain cases.[5,6] The chief route through which the blood stream is seeded is by way of the pulmonary artery into the dilated vascular bed of the lungs and from here to the left heart and general circulation.[2,5,6] Postoperatively, the factors responsible for the dilatation of the pulmonary capillaries are eliminated.[6]

*Natural History of the Unoperated Case*—The size of the ductus appears to bear a relationship to the general health and length of life. A large ductus may impair the general health and shorten life consider-

*The address of the Retiring President presented at the Annual Meeting of The New Haven County Medical Society, New Haven, April 1944*

ably.[7] The oft quoted figures of Abbott[8] show that of 92 fatal cases of patent ductus arteriosus, in the absence of other cardiovascular congenital anomalies, forty-three per cent died of cardiac failure and thirty per cent died of subacute bacterial endarteritis. Recent statistical analysis in adults indicates that there is an average reduction in life expectancy of about twenty-three years in men and twenty-eight years in women.[9] Death was caused by subacute bacterial endarteritis in over twenty per cent and by congestive heart failure in nearly thirty per cent. In addition, operation on adult cases revealed pulmonary aneurysms in fifteen per cent and the frequent occurrence of atheromatous and calcareous placques. For the above reasons, it is obvious that operations should be performed when possible on every patient with a patent ductus during childhood.[9,12]

*Improvements In Operative Technique*—The success of the first operative closure of the patent ductus by Gross and Hubbard led to its trial in many other cases including those complicated by infection in the patent ductus. It was found that infected cases required more gentle manipulation during ligation[6,10] and as the courage of the operators grew after Gross's lead, ligation and division of the ductus became a common practice. Another approach posterolaterally and transpleurally was suggested[7] but it is doubtful if it will ever rival the original operation devised by Gross.

It was at first believed that the infected patent ductus arteriosus should not be operated upon due to the danger of manipulating the infected, thrombotic blood vessels. This is chiefly one of embolus production and hemorrhage.[11] Touroff[6] demonstrated that ligation could be performed and the patient cured in a majority of the cases. Sufficient evidence has now been accumulated to show that ligation or division of the infected ductus is urgently indicated.[6,7,10] These reports take on increased significance as the study of the mechanism of action of surgery will, it is hoped, yield information on the nature of bacterial endocarditis.

### B. ARTERIOVENOUS ANEURYSM

The war has served to place added emphasis on problems resulting from injury to the heart and blood vessels and some of them can be mentioned here.

Like the patient with patent ductus arteriosus, the untreated case of arteriovenous aneurysm may develop congestive heart failure, the effect upon the circulation being, for the most part, similar to that of patent ductus arteriosus. This has been well known for many years.[15] Although spontaneous cures have been reported,[16] treatment by ligation and excision is recommended to avoid the serious complication of congestive heart failure. Fortunately, even though this complication becomes established, it is completely relieved by closure or excision of the fistulous communication. Complete cure has also followed excision of arteriovenous aneurysms complicated by infection and septicemia,[13,14] although this procedure was also believed to be contraindicated in the presence of infection.

### C. PENETRATING WOUNDS OF THE HEART. CARDIAC TAMPONADE

The United States Army has recently published directions for the diagnosis and treatment of heart wounds with associated cardiac tamponade.[18] These are:

(a) Aspirate the blood from the pericardium by the costo-xiphoid route, if possible.

(b) Repeat if there is a recurrence.

(c) If it occurs again, perform a cardiorrophophy through an extra-pleural exposure.

These directions were prepared for medical officers in the Army by E. A. Graham, I. O. Bigger, E. D. Churchill, and Leo Eloesser.

Blalock and Ravitch[19] support this view and have published the results of their experience.

The diagnosis is based on the observation of rapid enlargement of the cardiac outline, absence of pulsations fluoroscopically, disappearance of heart sounds, marked increase in venous pressure, and signs and symptoms of collapse.[18,19]

### D. OMENTAL TRANSPLANTS IN CORONARY SCLEROSIS

Stimulated by the observations of O'Shaugnessy[22] and others, Friedbacher has further elaborated this work in experimental animals. He noticed that while muscle grafts become quite firm and interfere with heart action, the omental graft remains pliable and large arterial anastomoses are formed.[21] Despite excellent graft of the omentum and the formation of numerous anastomoses of good size, infarction following division of one coronary artery could not be prevented and division of the second coronary led to the death of his animals in ten to thirty minutes.[20]

### E. CHRONIC CONSTRICTIVE PERICARDITIS

Follow-up studies of cases of chronic constrictive pericarditis[23,24] have been extended over a sufficient

time to furnish satisfactory analysis of the end result of surgical treatment. The mortality of the operation calculated on the basis of twenty-eight cases submitted to surgery is eighteen per cent.[24] Blalock and Burwell[23] also encountered a relatively low mortality rate. That not all patients need surgery has been proved by the experience of Harrison and White,[24] but indications for surgical intervention are clear cut in cases of constriction associated with pyogenic infection and in the case of marked constriction in patients with tuberculosis whether active or inactive. Where the symptoms of constriction are moderate and due to an active tuberculous infection, it is advisable to delay operation until the infection becomes inactive.[23] Prognosis of the untreated case is associated with a mortality of about 80 per cent, whereas operation reduces the mortality to from fifty to sixty per cent.[25] Of twenty-eight operated cases, Harrison and White list fourteen as cured clinically by surgery.[24] Tapping of serous cavities, low salt and fluid intake, and the use of diuretics are helpful when disability is mild and for the preoperative preparation of the severe case. Digitalis is not generally indicated except in the presence of auricular fibrillation and when there is myocardial weakness due to atrophy.[23]

### F. APPROACH TO INTRACARDIAC SURGERY

The field of cardiac surgery will probably be considerably broadened by the perfection of instruments for intracardiac visualization, Endoscopy has now invaded almost all body cavities and in each instance has contributed to direct therapy and to our concepts of physiology and pathology. Recently, Harken and Glidden[26] have devised a new cardioscope which it is hoped will stimulate the development of more efficient instruments for the examination of the interior of the heart.

## II. Hyperthyroidism

### THIOUREA AND RELATED COMPOUNDS

Early in 1943, Astwood introduced the new drugs, thiourea and thiouracil, for the treatment of Graves Disease,[28,29] the practical application of which followed studies of the effect of these and related compounds on the activity of the thyroid gland.[28,32] Thiouracil was found to be the most potent and the least toxic and has been submitted for clinical trial in a large number of cases of hyperthyroidism. The drug inhibits the formation of thyroid hormone, and produces a fall in B.M.R. and a decrease in protein-bound blood iodine in cases of thyrotoxicosis within four weeks.[28,30] In fact, given in sufficient dosage, one can obtain a drop of the B.M.R. even to the level of myxedema. The disturbed metabolism of calcium, phosphorus and creatinine is corrected. Exophthalmos is not relieved. The patient, however, is entirely relieved of the symptoms of hyperthyroidism. In the doses recommended by Astwood, signs of intolerance to the drug are rare, consisting for the most part of a garlic odor to the breath and an occasional erythematous eruption of the skin. In larger doses ranging up to 0.8 gram, t.i.d. used by some clinical investigators, agranulocytosis, fever and more pronounced skin manifestations have been reported.[31]

It is to be expected that if thiouracil relieves hyperthyroidism, it would be employed not only as a permanent treatment but also as a preoperative measure in severe hyperthyroidism. Bartels[61] has reported its use to lower the metabolism preoperatively in eleven severe cases of hyperthyroidism and found it an excellent agent in this regard. However, the hyperplasia resulting from the use of thiouracil led to increased bleeding during the operation. It should here be pointed out that the administration of iodine prior to thiouracil greatly retards the response because of the increased thyroxin in the gland, but when used in conjunction with thiouracil may produce some involution. Astwood[29] has suggested the application of the drug in the treatment of thyrocardiacs. Because thiouracil is so effective in producing the myxedema state, doubtless its use will be extended to patients suffering with congestive heart failure and angina pectoris.

The following are two case reports of hyperthyroidism complicated by diabetes mellitus and paroxysmal auricular fibrillation which made surgical intervention especially hazardous.

#### CASE I

I. W., female, age, 55. This patient had been ill for thirteen years with diabetes, hypertension for four years and was having recurrent attacks of rapid irregular heart beat for two years.

She was thin and undernourished. Slight enlargement of the right lobe of the thyroid was noted. No abnormal occular signs were present. There was fine tremor of the fingers. The cardiac apex was in the anterior axillary line. The sounds were loud, rhythm was regular, A2 markedly accentuated. The blood pressure was 200/80, weight 94 lbs. On admission to the hospital, the B.M.R. was plus 54, R.B.C. was 3,930,000, W.B.C. 13,350 and Polys 74 per cent. Blood sugar was 120, N.P.N. +43. She had a negative Wassermann. Urine—Sp. Gr. 1040. Alb. ± to 4+, sugar ± to 4+. W.B.C. numerous with clumping. The patient was receiving digitalis, quinidine sulphate, diabetic diet and Insulin. On admission,

she continued to have recurrent attacks of auricular fibrillation of short duration which were controlled by quinidine. The ventricular rate was 128. Thiouracil was administered in the doses recommended by Astwood, 0.6 grams daily for three days and thereafter 0.1 grams. twice daily. The response was slow but steady. The B.M.R. declined to +23. The attacks of paroxysmal fibrillation disappeared after treatment for one month. The diabetic state, however, was not greatly altered. The gain in weight and the general feeling of well being and loss of inward tension was pronounced. However, the thyroid gland did enlarge somewhat.

CASE II

T. E., male, age, 51. For over a year the patient had frequent attacks of rapid heart beat coming suddenly and subsiding suddenly lasting variable periods of time. They left him weak. He had nocturia and frequent urination during the day for about a year. There is a history of weight loss, although his appetite is good and food intake considerable.

The significant physical findings were: visible sclera above the iris, fine tremor of tongue and fingers. The right lobe of the thyroid was definitely enlarged and uniformly soft. The heart sounds were augmented, the rhythm was regular and the rate rapid. Blood pressure was 138/80—weight 117 lbs. On admission to the hospital, Hgb was 96 per cent Dare, R.B.C. 5,090,000, W.B.C. 13,000 and Polys 78 per cent. Urine: Sp. Gr. 1032, Sugar ++++. He was on a diabetic Diet c Insulin.

Thiouracil was started in dosage of 0.6 gram for three days and 0.2 gram daily thereafter. In sixteen days, the symptoms of tachycardia, nervousness and irregular heart beat disappeared. The flushed skin gave way to a more normal pale hue. The sugar disappeared from the urine and the patient became symptomless. The B.M.R. in a month was +9.

## III. Rheumatic Heart Disease

SULFONAMIDES

That there is a relationship between rheumatic fever and hemolytic streptococcus infection has been established and the largest group of primary attacks are known to follow infection with B. hemolytic streptococcus. Recurrences are often preceded by respiratory infections due to this organism in the large majority of cases.

The use of sulfonamide to perevent hemolytic streptococcus infections has been reported,[35,36,62] and its value in the quiescent cases of rheumatic fever is measured by the degree to which such infection can be prevented. In an important study by Holbrook[62] on a large group of Army Air Force personnel, 1 gram of sulphadiazine given daily over long periods of time greatly reduced the incidence of hemolytic streptococcus infections and at the same time almost eliminated fresh and recurrent attacks of rheumatic fever. Once the streptococcus becomes implanted, the sulphonamides apparently cannot prevent occurrences of rheumatic fever or affect its course.

Coburn and Moore[34] treated quiescent cases of rheumatic heart disease who already had throat infections, when cultures from these patients yielded Group A hemolytic streptococcus by giving four to six grams of salicylates daily. Of 47 patients so treated only one developed symptoms of rheumatic fever. Of 379 controls, 57 had recurrences. Thus it appears, if confirmed, that salicylates can prevent the rheumatic manifestations of hemolytic streptococcus infections.

Coburn[37] has carried his studies with salicylates further by studying the relationship of the blood salicylate level to the course of rheumatic fever in young soldiers. He administered larger doses of salicylates intravenously. A simple method for the determination of plasma salicylates is described. Twenty patients maintained at plasma levels of 359 to 400 micrograms / c.c. manifested prompt subsidence of rheumatic inflammation. Twenty patients with plasma levels below 250 micrograms per c.c., continued to manifest an active inflammatory process. The intravenous administration of sodium salicylate is required to obtain a rapid rise in concentration. Thirty-eight patients with rheumatic fever were treated with large doses of salicylates. None developed rheumatic valvular disease. If these findings are confirmed, they should be an important addition to our attack on rheumatic fever and the resulting cardiac damage.

The knowledge that a reduction in blood prothrombin level occurred in human beings[59] and animals given large doses of salicylate over a long period of time introduces an additional problem in treatment. Vitamin K prevented the drop of blood prothrombin if it was given before this drop occurred but it was not effective in the treatment of patients in whom the prothrombin level had already been considerably decreased.[60] It would, therefore be rational to give Vitamin K together with salicylates especially when large doses are employed in order to prevent hemorrhagic phenomena.

## IV. Anemia and Heart Disease

INFARCTION

Since oxygen supply is the determining factor in life and death of cells, the amount of blood supply to a heart already impaired by arteriosclerotic narrowing can assume critical importance. This has been strikingly illustrated in the accompanying case

report in which the patient, following massive gastric hemorrhage, developed myocardial infarcation. Treatment consisted of immediate transfusion with large amounts of whole blood.

CASE I

A. M., male, age 52. This old sewer inspector was well until three days prior to hospital admission when he suffered severe hemetemesis, fainting and passage of tarry stools. Shortly thereafter he developed severe precordial pain. He was brought to the hospital in shock. This patient had a gastric hemorrhage twenty-three years ago. Examination revealed signs and symptoms of shock. The heart sounds were distant and the rhythm regular. No murmurs. The lungs were clear. There was soft abdominal distention. On admission the blood count showed R.B.C. 1,360,000, Hgb. 48 per cent, W.B.C. 15,800, Polys 84 per cent. Sugar 157, N.P.N. 42 ECG revealed evidence of infarction involving the posterior right and left ventricles. Course: The patient was placed in shock position. He was complaining of slight chest pain during most of the second day. On the first and second day he was given 1000 c.c. of 5 per cent glucose in saline and 500 c.c. of whole blood with 5 c.c. of Adrenal Cortical Extract. On the third he was acutely ill with high fever. Daily blood transfusions were given during the first week and he was put on a Sippy diet on the third day. There was a progressive rise in R.B.C. and hemoglobin. No further chest pain was experienced. At the time of discharge the R.B.C. was 3,900,000 and Hgbn. 65 per cent.

## V. Angina Pectoris

Several reports of angina pectoris in association with anemia have been published. That of Bernstein and Ginzburg[40] is typical of the experience of others. These authors have presented a report of a case in which status anginosus occurred in a patient with severe anemia due to the presence of malignancy of the gastro-intestnial tract. Transfusions of whole blood completely relieved the patient of pain.

## VI. Congestive Heart Failure

While the number of reported cases of congestive heart failure precipitated by anemia is small, we have encountered cases of heart failure associated with severe anemia in whom prevention of further loss of blood and transfusion have restored them to compensation when ordinary methods proved to be inadequate. The following case is illustrative.

CASE I

T. K., female, age, 43. For a year, this patient had dyspnea on moderate exertion. For the past two months, more dyspneic with onset of leg and ankle edema. Orthopnea came on two days ago. There is a history of dry cough for years which became productive in past week. No hemoptysis. There was a history of tarry bowel movement on the day of entry. No other episodes. The patient had been a known diabetic since 1938. Well controlled now. Periods regular. Diet, adequate. Was menstruating on admission.

Examination showed B.P. 100/60, pulse 104, very pale, dyspneic, orthopneic. The neck veins were markedly distended. There was impaired resonance with diminished breath sounds in both lung bases and many coarse and fine moist rales throughout both lungs. The heart tones were weak. No murmurs were heard. The rhythm was regular. The apex impulse was in the anterior axillary line. The liver edge was easily palpable. There was pitting edema of both ankles and legs. The cardiologist felt that the patient did not have arteriosclerotic heart disease, the admission diagnosis, and the presence of free HCl in the fasting stomach eliminated pernicious anemia as a cause for the low blood count. On admission the R.B.C. was 2,940,000, Hgb. 55 per cent, blood sugar 65 per cent, N.P.N. 22. P.S.P. excretion 67 per cent in two hours.

The patient was digitalized, given ammonium chloride and theobromine. On the second day, 2 c.c. of Mercuperin was given intravenously and a tremendous diuresis led to much clinical improvement. Except for digitalis effect, the electrocardiogram was normal. X-ray examination of the chest showed pulmonary vascular engorgement and marked cardiac enlargement. Stools were negative for blood.

On the twentieth hospital day, a history of menorrhagia of long duration was elicited. The patient had vaginal spotting in the hospital. Pelvic examination revealed a uterus the size of a two to three months pregnancy which contained several large myomata. D and C was performed with insertion of radium. Blood transfusions were given. The heart size diminished as was demonstrated by the serial roentgenograms of the chest. One year later, the patient was on normal activity without digitalis.

## VII. The Heart In Nutritional Deficiencies States

VITAMIN B

Freedberg and Blumgart[41] have described a case of heart disease with signs of vitamin deficiency in whom oral administration of thiamine chloride was ineffectual in combination with known therapeutic measures for heart failure. Their patient continued to fail until parenteral administration of Vitamin B complex together with thiamine chloride, 100 mgms daily was started, when recovery occurred with the most amazing rapidity.

Johnson et al.[42] have shown that in healthy laborers, on diets deficient in Vitamin B, signs of $B_1$ deficiency may appear in a few days. The reason for the early appearance of symptoms in persons doing hard work is that the increased carbohydrate metabolism uses up large amounts of thiamine. In patients with organic heart disease, anorexia and congestion of the gastro-intestinal tract leads to impaired absorption as well as deficient utilization of Vitamin B. In many patients with congestive heart failure, signs of vitamin deficiency are usually present and are treated. However, in the absence of

clinical avitaminosis in the patient in whom heart failure is not relieved by the ordinary methods, parenteral Vitamin B complex and thiamine chloride ought to be administered.

## VIII. Bacterial Endocarditis

### TRENDS IN THERAPY

It was early recognized that the sulfonamides would not produce the result which had been anticipated. The use of heparin with sulfonamides has also not yielded satisfactory results.

Penicillin had been used in bacterial endocarditis with such little benefit that the Committee of the Office of Civilian Penicillin Distribution at first thought it inadvisable to release penicillin for use in such cases. Loewe's[43] striking cures served to focus attention once more upon the possibility of cure with penicillin by employing much larger doses. Loewe, however, did not test the use of penicillin alone in bacterial endocarditis but combined penicillin with heparin. The febrile reactions from the use of heparin together with the considerable local discomfort resulting from the injection makes it desirable to reinvestigate the value of penicillin alone in bacterial endocarditis. Apparently, some of the early failures of penicillin in the treatment of bacterial endocarditis must be attributed not alone to the low doses used, mostly under 200,000 units daily, but also to the method of administration. It is known that blood levels following intramuscular injection of penicillin are not long maintained but fall off quickly. Only continuous intravenous drip can maintain a high, constant level of penicillin sufficient to sterilize the blood.[44]

## IX. Digitalis Bodies

Several new purified digitalis bodies have been made available. These are fully as effective as the preparations of digitalis leaves now in common use.

In considering criteria for the choice of any digitalis preparation in a particular case, one must take into account its properties along the following lines.

a. Absorbability.
b. Tolerance.
c. Rate of disappearance from the body.
d. Speed of action.

### DIGITOXIN

Digitalein Nativelle has the advantage of complete absorption and speed of action when given by mouth. Due to rapid excretion of the drug it is not easy to maintain digitalization. Absorption is apparently as complete by mouth as by vein. By either route, 1.25 milligrams or 3 cat units is a full digitalizing dose.[45] The full effect is achieved in six hours or less.

### CEDILANID

This preparation is characterized by a constancy of potency. Its action by the intravenous route is only slightly less rapid than digitoxin. Absorption from the gastro-intestinal tract is not complete and larger doses are necessary to achieve full digitalization.[45] For maintainance of constant digitalis effect, this drug is not as satisfactory as the digitalis leaf.

### OUABAIN

When the need for full digitalization is most urgent, and the patient has not previously received digitalis, Ouabain is the drug of choice. It can be given by vein or by the intramuscular route. Eggleston advises that the dose be placed in 10 c.c. of fluid and five to ten minutes be allowed for injection. The effect begins in a few minutes and reaches its maximum in about one hour. Ouabain is rapidly excreted, but is so slowly and irregularly absorbed from the intestinal tract that its oral use is contraindicated.

The advantage of the purified preparation lies in the more rapid absorption, greater speed of action and greater tolerance by the patient. The rapidity of excretion makes constancy of dosage difficult and successful treatment uncertain. Digitalis leaves remains the most satisfactory preparation for maintainance of physiologic digitalization in the vast majority of patients. It must not be forgotten, however, that an occasional patient is encountered who does not tolerate the digitalis leaf and in such a case only a purified preparation can be effective.

## X. Coronary Occlusion

### NOMENCLATURE

The most precise pathological studies have revealed that subintimal hemorrhage is the cause of the sudden closure of coronary arteries in nine out of ten cases and that thrombosis of a coronary artery is a rare phenomenon. For all practical purposes the term "coronary occlusion" has rightly replaced the term "coronary thrombosis" in the diagnosis of myocardial infarction.

### PATHOLOGY

Recent investigation has revolutionized the diagnosis and the treatment of coronary occlusion. These

studies were made possible by new methods of dissection and injection of the heart. We now know that complete occlusion of one or more coronary arteries may exist without giving rise to clinical signs or symptoms and without having produced myocardial damage. Persons suffering primarily from angina pectoris have, at post-mortem, shown complete closure of a major coronary artery. Adequate collateral circulation prevents muscle necrosis. Thus one can have coronary occlusion without infarction.

CLINICAL

In the light of these findings our understanding of the clinical picture which may result during and after coronary occlusion has been clarified, and therefore the treatment can now be more intelligently planned. The classical picture of infarction is well known. Emphasis must then be placed on the importance of recognizing prodromal symptoms. Boyer[48] identified three patterns. (a) Sudden onset of pain characteristic of coronary occlusion where clinical signs and symptoms of myocardial infarction do not appear early. Some other diagnosis may be made. (b) Sudden onset of angina pectoris in a patient previously well. (c) Sudden increase in severity and frequency of anginal syndromes. The probability of imminent infarction should be considered in all such cases and measures to allow the formation of collateral circulation and avoid infarction instituted. These include bed rest, light diet, avoidance of tobacco, and the administration of vasodilator drugs.

In such cases it is hoped that enough collateral circulation may be engendered or already exists to prevent necrosis. Two to three weeks of rest is usually sufficient.

## XI. Myocardial Infarction

The treatment of the case with myocardial infarction has been outlined in two excellent contributions[49,51] about as follows:

(a) Reduce the work of the heart by absolute mental and physical rest; i.e. through the use of morphine and atropine. Reduce caloric intake.

(b) Increase the oxygen supply by the oxygen tent or B.L.B. mask and by employing vasodilator drugs; e.g., aminophylline, theobromine, papaverine.[50]

(c) Maintain cardiac nutrition by means of vitamins added to the diet and, in the presence of anemia, by transfusion of whole blood.

(d) Prevention of complications;

(1) Ectopic rhythm by means of barbitrates, quinidine, papaverine.[50]

(2) Distension.

(3) Thombosis of leg veins.

(e) Treatment of complications; e.g.

(1) Arrhythmias by quinidine.

(2) Adams-Stokes syndrome by adrenalin.

(3) In syphilitics discontinue treatment.

(4) Congestive heart failure by mercurial diuretics and digitalis.

(5) Shock. Paredrine by hypo may be effective.

## XII. Angina Pectoris

Riseman[63] has divided all cases of angina pectoris into three major groups according to their response to nitroglycerine. Group I comprising twenty per cent are marked reactors. Group II are moderate reactors, some thirty-three per cent. Group III, the remainder, forty per cent, have little or no response to nitroglycerine. In a given period of time, the highest mortality occurred in patients of Group III. Riseman studied the effects of sixty-eight different methods of chemical physical and surgical treatment and we may now be guided by his results as well as by personal experience. The routine treatment of angina pectoris should then consist of:

(a) Elimination of precipitating factors such as walking, heavy work, excitement, cold.

(b) Eliminination of basic factors such as hyperthyroidism, anemia, polycythemia, obesity.

(c) Medications—nitroglycerine, Theobromine, sedatives, aminophyllin, quinidine for arrhythmias.

The recent claims for testosterone propionate as a therapeutic agent in angina pectoris have not been substantiated.

## XIII. Sudden Death Due to Aminophyllin and Mercupurin

Examination of reports of sudden death "due to" Aminophylline and Mercupurin fail to disclose conclusive evidence for the claims. Since the cases reported all had severe heart disease or were otherwise critically ill and sudden death is a frequent complication in such cases regardless of treatment, the intelligent use of such important agents should not be discontinued on the evidence presented.

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# SCHOOL HEALTH PROBLEMS AS SEEN IN A PEDIATRIC CLINIC

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I am not experienced in all of the manifold activities of school health work; my contribution to your conference this afternoon—in the preparation of which I have had the assistance of several colleagues[1]—is based on a rather circumscribed segment of the subject such as comes to a physician associated with a hospital Children's Clinic. Here children under sixteen years come for diagnosis and treatment; admissions are conditioned only on the ground of limited financial resources. I hope you will keep in mind this basic experience from which my remarks stem; however, from discussions with colleagues who are in the private practice of pediatrics, I conclude that most of the ills of childhood are not respectors of economic privilege except in a few categories such, for example, as rheumatic fever.

In a clinic such as I have described one sees bizarre and unusual diseases but they are rare and play no part in an over-all discussion of school health problems. I have in mind such diseases as leukemia, brain tumor, cretinism and many disorders of the central nervous system. Even such a clear-cut disease as diabetes mellitus, for example, is really uncommon since, Dr. Linde tells me, there are only 18 cases in the New Haven schools; nine of these attend our Clinic. Individually, such cases as I have mentioned are of tremendous interest and importance but they are of minor significance in a consideration of the total problem.

What, then, are the important school health problems as we see them in the Clinic?

First of all, come respiratory infections particularly those of the upper air passages—the common

1. I am especially indebted to Doctors Edith Jackson, Joseph Linde, Herbert Miller, Helen Richter and to Miss Alice Grant and Mrs. Alice Howell.

*Given at the Second Wartime Conference on School Health Education, New Haven, October 6, 1944*

cold, so-called "flu," enlarged or diseased adenoids and tonsils, running ears, sinusitis, bronchitis. Probably over one-third of the school children seen in our Clinic have one or more of these vexing conditions—vexing because they are so numerous and because for so many of them medical science has little to offer in prevention or cure. You will note the absence of diphtheria from my list; that is because immunizations carried out by the Department of Health and by private physicians have eliminated that scourge from this community. For the "common cold" physicians recommend isolation and "rest in bed"—a prescription too little followed. Did we heed it, more serious infections for which the "cold" prepares the way might be reduced in frequency and severity. Rest in bed also tends to isolate the patient so that he is less likely to infect other children—a matter of major importance should the "cold" actually be an infection due to the streptococcus.

Infections caused by the hemolytic streptococcus are frequent in this community especially in the winter and spring months; scarlet fever is one of these diseases and its incidence varies considerably from year to year; streptococcal sore throats are more common, often masquerading as the common cold. Many persons, not ill, are carriers of the streptococcus which in other persons may cause scarlet fever and severe sore throats. That is the reason that isolation of cases of scarlet fever is probably of no greater importance than is the isolation of other forms of streptococcal disease. All physicians agree that the sulfonamide drugs and penicillin are of great value in the treatment of the complications of scarlet fever and streptococcal sore throat; I myself believe the drugs are of little value in the uncomplicated cases.

For the epidemic respiratory infections such as we had in New Haven last fall and early winter and which some call influenza, we have neither prevention nor cure; rest in bed is good treatment too seldom carried out.

I have now spoken of the commonest acute infections of the upper respiratory tract. What of tonsils and adenoids? I think you would be amazed at the number of children who come to us for "tonsils," as the mothers express it, and in our opinion those much maligned glands have nothing the matter with them. If we were to believe all we hear, mental retardation, emotional instability, malnutrition, obesity, tuberculosis and what not are caused by "tonsils"! The many fine things removal of tonsils is thought to do for children are really incredible! Perhaps I am somewhat of a heretic on this point but I believe I am reasonably near the truth. Let me make myself clear: adenoid tissue should be removed if it is large and obstructs the air way, or if small and obstructs the opening of the small tube in the throat draining the middle ear. Tonsils should be removed if so large that they interfere with swallowing or breathing—a rare condition—or if definitely diseased, as evidenced by enlarged glands in the neck, by fever and by cough—all not otherwise explained. All physicians may not agree with my protective attitude toward tonsils but I bring the matter to your attention with a clear conscience because so often parents and teachers are disappointed with the negative results of tonsillectomy when actually the operation was never indicated and could not possibly have influenced the condition from which the patient actually suffered.

Allergic diseases—pollen fevers and asthma—constitute an important group in our Clinic; the patients cannot be cured but their suffering can usually be alleviated. There are forty school children in our special allergy clinic, twenty-six of whom have some form of pollen sensitivity and fourteen have asthma or asthmatic bronchitis. Allergic eczema is not common in school children being a form of protein sensitivity most frequently seen in pre-school children. I should point out here that in many cases of asthma there are psychological quirks which if smoothed out bring more relief than do more orthodox forms of treatment.

Of the specific communicable diseases other than diphtheria and scarlet fever already mentioned, whooping cough and chicken pox are the most common causes of visits to our Clinic; these diseases account for much school absenteeism during certain years. Measles was a common affliction last year as you well know.

Concerning tuberculosis we have in our special clinic, 79 children between 6 and 16 years of age who have been diagnosed as active disease and there are 225 who are contacts and under observation. The splendid work of Dr. Linde both in the Department of Health and on the State Tuberculosis Commission in x-ray spotting of active cases and placing them in sanatoria, thus preventing family and other dissemination of the germ, will probably reduce even further the incidence of the white plague.

Skin diseases comprise another large group of clinic disorders in children. These diseases are always a nuisance—rarely are they serious. Many are minor

infections, secondary to pediculosis, ring worm and scabies; a few are primary infections and constitute the more serious problems in this category. There are innumerable little understood but largely benign rashes which do not last long; they are important because they must be distinguished from the rashes of certain contagious diseases.

One of the most serious school health problems is that of rheumatic heart disease. In our special clinic we have 188 school children with that disorder; there are 443 known to our school nurses. The disease tends to be more frequent in families economically underprivileged. Rest, good hygiene and protection from infection are our only uncontroversial methods of treatment for these patients. It is obvious that these recommendations are difficult to carry out—particularly in the very mild cases or in those under suspicion, even in the most privileged home; the emotional repercussions of actual or forced invalidism, partial or complete, are often serious. The rheumatic child has no brace or crutch and to his fellows and himself seems well. Segregation of similarly afflicted children as is done in our Children's Community Center is helpful psychologically and educationally as well as therapeutically.

In regard to dental defects they are seen in our clinic in large number; despite the great advances in our knowledge of nutrition we still are greatly in the dark regarding the causes of dental caries and and many other diseases of the teeth. That such is the case is demonstrated by the high incidence of dental disorders recorded in selective service examinations.

Many children come to the Clinic because they have defective vision or audition. It is highly important that such handicaps if on an organic basis be diagnosed and the patient receive such medical treatment as is available; educational consideration must, of course, be given such children in respect to special seating and special classes. However, without weakening the statement just made, I want to point out that some children brought to us for visual or hearing defects which are simulated rather than organic. This situation obtains in children who are mentally retarded or emotionally disturbed. That a vicious circle may develop in certain cases is clear since the strain of trying to see or hear when these senses are defective may lead to emotional outbreaks. One expression of emotional tension in some cases often wrongly suggestive of eye strain is blinking and squinting; these and similar frequently repeated purposeless muscular movements always tracing the same pattern in each patient, are called tics or habit spasms. To call attention to such grimacing or twitching is to make it worse; to find and relieve the source of strain and tension is the only treatment. The affliction in greater or less degree is one in which most of us share.

As you know epilepsy is a very important and serious school health problem; there are two major forms—*grand mal* in which there are convulsions with loss of consciousness and *petit mal* in which loss of consciousness, often momentary, is the characteristic feature. It is roughly estimated that there are one-half million persons in the U. S. with this affliction—about .4 per cent of the population. In our special neurological clinic there are registered some 100 children with epilepsy, about equally divided between grand mal and petit mal.

Certain cases of grand mal are associated with mental deteriorization and do not properly belong in any public school. On the other hand many epileptic children particularly those with petit mal are bright children and can do the same work as their more favored confreres of the same age. Out of a series of 1,600 cases Lennox notes that 67 per cent are of normal mentality and another 23 per cent only slightly subnormal—ratios probably not too different from those of the non-epileptic population.

Many epileptic children behave in a peculiar manner; they are ashamed and frustrated and insecure. Some of this bizarre behavior may be the direct result of organic disease but I believe much is attributable to the attitude toward them of those with whom they are in contact. If instead of ostracism, we accept epileptics into the bosom of our friendliness and sympathy to even a greater extent than we do our favored pupils, we shall find, in the vast majority, that many disturbing vagaries of conduct will disappear and seizures will diminish in number. Disregard of the emotional suffering of these children and treatment of overt conduct with severe disciplinary measures tend to increase difficulties. On the other hand, a sympathetic understanding of the nervous and emotional instability of the child's reactions, stressing positive assets and accepting difficulties without critical comment tend to minimize both emotional outbreaks and seizures. And, in many instances, learning capacity seems to increase.

In the electroencephalogram we have a laboratory procedure simple to perform, which is most helpful

in establishing a diagnosis of epilepsy particularly of the petit mal type in children with peculiarities of conduct. A diagnosis could not otherwise have been made in many cases.

I have now sketched the problems of physical illnesses which constitute the bulk of our work in that category with school children. An adequate physical examination is required to make a diagnosis and to prescribe treatment. But these physical ailments comprise only two-thirds or three-fourths of our work with school children; the remainder lies in the realms designated disorders of behavior and mental retardation. Not only do mental and emotional disturbances make up a sizeable part of our clinic work, but they probably far outweigh all organic diseases combined in their devastating effect in reducing happiness. Few of these children are sent to us because they are failing their school work—such frank cases are probably sent to the Clinic of Psychiatric Service in the community. Our own patients come under the guise of some physical ailment. Most mothers, sensing the fact that something is not just right, blindly blame the tonsils, appendix, eyes and ears and often request that a tonsillectomy be done right away. One mother's complaint was that her little girl had "scrofula"—a lay term for tuberculosis of the glands of the neck; actually the child was organically sound but had a severe psychological disorder and retardation.

The handling of the tremendous problem of mental deficiency is the joint responsibility of the public schools through special classes and of the two special State Training Schools for mental defectives. Household, industrial and agricultural training supply the chief opportunities for the higher grades. Forcing these children beyond their abilities accomplishes nothing good and much that is bad in the form of overt conduct, often a reaction to failure and frustration. One of our most important joint enterprises—school and clinic—is the recognition of cases of mental deficiency in order, on the one hand, that dull children may not be forced into behavior disorders by undertaking work they cannot master; and on the other hand, that bright children may not be held back to the speed of their less favored schoolmates.

Many school children have emotional difficulties some of which are obvious, others well concealed. Life requires of us one series of adjustments after another—and these are too many and too difficult for some children to achieve, particularly in these tragic times. Such children come to us in the sincere guise of some physical ailment. The complaints are numerous—breathlessness, headache, dizziness, stomachache, vomiting, fears of vomiting, enuresis, twitching, squinting, fidgetiness, asthma, stuttering and stammering, facial tics (to which I have already referred), joint pains, palpitation of the heart, peculiar eating habits and so on. Obviously, children with any one of these signs or symptoms may be organically ill and such disability may be the cause of scholastic and social maladjustment. I have already referred to epilepsy and encephalitis as causes of emotional disorders and there are a host of other organic diseases with psychic components. Diagnosis must be accurate. But in many cases the physical evidences of disease are but the somatic (that is bodily) expression of psychic dysfunction. This occurs so frequently in medicine that we now use a dignified name and speak of psychosomatic medicine. Scholastic difficulties may lead to psychic disturbances with or without physical expression and emotional disturbances may lead to failure in school and, sometimes, physical ill health; what is cause and effect in one case is effect and cause in another. A deaf child may appear dull and inattentive because of the strain of trying to hear from the back of the room; another child may appear hard of hearing because he is anxious and distraught.

I do not know whether or not the psychosomatic emotional disturbances seem to you remarkable in kind and number. To us they are remarkable and of great importance. I could give you illustrations; a girl who had to stay out of school for fear of vomiting; a boy with choreaform movements of the right arm and temper tantrums associated with sex play; an asthmatic son of an over-anxious mother who talked constantly of death; a boy with abdominal pain from a home where the father was alcoholic and the mother over solicitous and inclined to force scholastic achievement beyond the child's ability; a sulky boy who had a reading disability with mixed laterality; a boy who was a "little devil" in school according to his teacher and who had petit mal; a girl, frequently absent from school because of headache, coming from a fatherless home where she was the butt of all the family difficulties.

Reading disability is practically certain to be accompanied by emotional maladjustment which may run from frankly expressed dislike of school and resigned acceptance of inferiority in academic accomplishment to acute behavior disorders either of

the aggressive or of the withdrawn type. If a child cannot read as well as the average for his age and grade he soon gets out of step with his group and the discrepancy grows worse and worse as he advances since reading becomes increasingly necessary to mastery of school tasks. No qualified investigator is willing to assign any one cause for reading disability; usually several factors, some or none of which may be physical, are associated. In every case there is bound to be emotional strain and this must always be recognized and dealt with along with the other factors involved.

One benefit that should accrue from close linkage of school and medical services would be clear recognition of the delayed effects of certain illnesses. Not only may children be listless, inattentive, "not quite up to par" as we say, on returning to school after some weeks of illness, there is some evidence that certian types of infections produce unfavorable behavior changes which will probably be spontaneously outgrown, they will almost certainly be accentuated by harshness and fault finding. It is not at all unusual to find in the past school history of children with scholastic disabilities, record of prolonged or repeated absences during the early years of school. There are gaps therefore in their educational experience, represented not only by absences but also by the days or weeks when they were physically in school but unable to profit intellectually by attendance.

It should be pointed out also that truancy and delinquency are often tragic evidences of emotional dysfunction. The absence of many fathers in the armed services and of mothers in defense work are important contributing factors to the difficulties of their children. So frequently in these situations there is neither father nor mother substitute left in the home.

In the total educational setup, cases of these types may seem of minor importance but as one views the school health problem in a clinic, such problems seem very common and pressing indeed—more than we can adequately handle with our staff. They illustrate the point I wish especially to emphasize, namely, that when things are not going well with a child in school—anything from fidgetiness to tantrums and absenteeisms—he should receive a medical examination. Routine physical examinations and inspections are important, particularly with regard to communicable disease control and to eligibility for athletics, but these examinations do not take the place of a special investigation at the time when there are evidences of physical and scholastic difficulties and of tangles in interpersonal relationships.

From our experience in the Clinic, it is clear that when a school child has a physical complaint some attention is usually paid to that complaint; a careful examination is indicated and it should be made by a physician who is not only competent to perform a physical examination but is also familiar with the psychological and psychiatric problems of school children. It is not so well recognized that exactly the same procedure is indicated and should be followed when a child is failing in school or has deviations from what is generally recognized as average, normal behavior. A competent physician should examine such children in order that an appraisal may be made of the relationship between complaints and organic, mental and emotional disease. But the study and treatment of such cases can or should seldom be handled singlehandedly no matter how able and understanding the physician; the problem is usually complicated and the therapy requires the special skills of psychiatrists, psychologists and social service or educational workers and usually extends over a long period of time.

In the past year in our special Pediatric Child Welfare Research Unit, an integral part of the Clinic, 126 children of school age were seen for psychological and psychiatric evaluation; this was only a fraction of the total number that should have been referred to the special unit. In some of these cases intensive psychotherapy was indicated and was undertaken by one of the child psychiatrists. In many cases the difficulties were relieved through social and educational adjustments effected by the joint efforts of the pediatrician, the psychiatrist, the psychologist, the family, the school principal and teacher and the special educational liaison worker attached to the Clinic. This is a cooperative approach to problems of child adjustment; information about the child gained from the physical examination and from statements made by child or parent is supplemented with first-hand reports on the school situation from a qualified and sympathetic observer—our educational worker. With the more rounded picture thus obtained, therapeutic work can be more satisfactorily undertaken by the psychiatrist and a more objective interpretation of the child's difficulties can be given the parent by the educational worker. Finally, clinical findings and recommendations can be carried by this worker to the school in terms

applicable to that particular situation, and, if principal and teacher so desire, specific recommendations as to remedial techniques and materials can often be given. We do earnestly believe that school and clinic must work hand in hand to give really effective help to the many children who now fall by the way through conditions entirely beyond their control.

It is known to all of you that many of the emotional problems of school children and adults have their basic origin in experiences which antedate the kindergarten and grammar school. The frustrations of infancy are reflected in the behavior difficulties of the preschool and school child and on up the line. In the Clinic we have recognized this fact in our attempt to give guidance in child hygiene to the mothers of first babies from the day the infants are born. The mothers find the service helpful and many fears and anxieties are prevented or allayed.

At a slightly later stage of child development, we feel that perhaps neither parents nor school authorities are quite aware of the emotional strain that may be involved for a child on first going to school. Some children, perhaps the majority, weather this crisis with very little overt disturbance. With other children the experience may be fraught with acute distress, resulting in temper tantrums or in a tremendous increase of timidity and of mother-dependence. School people tend to think of such manifestations purely as bad habits to be broken down or controlled as soon as possible in the interests of a social conformity in the school room which is supposed to be desirable and necessary. They overlook the damage that may be done by an over-hasty and forced accommodation, on the child's part, to a situation for which he is not yet ready. Most child psychologists, at present, recommend that children's first school contacts be informal, that flexible arrangements as to attendance be made and that mothers be encouraged to visit school frequently and become acquainted with their children in a new setting.

Clearly, the fierce and growing impact of war on the lives of children and adults alike together with other considerations make alleviation of these problems I have discussed among the "felt necessities" (as Justice Holmes would have called them) of our time. We children's doctors believe we have a contribution to make in this domain in close cooperation with our school teacher friends.

In conclusion, may I summarize my point of view on this important subject by quoting an inspiring page from a little book entitled, "The War and Mental Hygiene in England" by Dr. James M. Mackintosh, Professor of Preventive Medicine in the University of Glasgow.

"Education must be the central feature of a post-war program for mental health. It is only through systematic health education, beginning with the expectant mother and carried on with unfailing continuity from infancy to adolescence in the child that one can hope to create a generation of healthy people. Children will become healthy in mind and body when training for health is woven into the pattern of education and made part of their daily life. Men and women can be healthy if they have been educated to want health passionately enough. Unfortunately education authorities have for the most part been content to offer health education in a desultory way, without giving it any emotional significance to the child. A system of this kind is bound to fail. It is a waste of public money because it pretends to do something which cannot be accomplished by that means. The consequence is that even preventive medicine spends its efforts upon the intermediate stages of disease. Child guidance, for example, is frequently concerned with behavior problems of children which could have been prevented by education; and the school medical and dental services spend far too much of their time in repairing faults that should not have occurred.

"The mental health movement will make little progress until the underlying problems of education are taken seriously by the authorities. The citizen must be made to realize his personal responsibility for healthy living; and responsibilities of this kind will not be accepted until they become absorbed into daily life from infancy onwards as naturally and imperceptibly as the functions of speech and walking and the habits of cleanliness.

"In the narrower field of prevention the greatest force is an active and happy life. The miseries that disfigure the lives of great societies are associated with enforced idleness, with drudgery, and with the fear that comes from insecurity. But regular employment and social security cannot by themselves prevent mental sickness although they may lighten its burdens. The capacity for enjoying work and making good use of leisure—the capacity for living the good life—can come only from within, and the only true begetter is education."

# CONFERENCE ON SCHOOL HEALTH EDUCATION

THE second wartime Conference on School Health Education under the auspices of the Connecticut State Department of Education, the State Department of Health, and the Connecticut Tuberculosis Association was held in New Haven on October 6, 1944. The first general session was presided over by Dr. J. I. Linde, Health Officer of the City of New Haven and President of the Connecticut Tuberculosis Association. A summary of the first general session and the section meetings appears below. It was prepared by C. E. A. Winslow, DR.P.H., with the assistance of Samuel M. Brownell, PH.D., Irma Pelz, Howard MacMullen, Esther Holmes, John T. Fulton and C. J. Prohaska, M.D.

The session opened with an address on School Facilities and Health, by Mr. John E. Nichols, Supervisor of Buildings and Plans, Division of Instruction, State Board of Education, Hartford. Mr. Nichols pointed out that many problems of school sanitation are associated with the presence of dirt and odors and emphasized the importance of janitation and of the cooperation of pupils in the maintenance of cleanly conditions. So far as air conditioning is concerned, he pointed out that suitable temperature, humidity and air movement are the factors of major importance rather than air change. He noted the fact that the natural lighting of many schools is unsatisfactory and penalizes the child whose seat is near the interior wall of the room. School teachers and administrators can minimize the evils involved by better use of movable furniture and of artificial light and by the decoration of rooms in a way which will avoid undue light absorption or glare. The gymnasium, when so managed as to give the majority of pupils a chance to learn and to enjoy games of skill and strength, is an important factor in school health. Finally Mr. Nichols pointed out that the health of children is influenced to a notable extent by emotional factors. The attitude of the teacher to the child, the quietness and freedom from confusion in the room, the attractiveness of the room itself, and the prevention of overcrowding—all of these are important to child health. They are largely under the control of the teacher; and "they are perhaps as important or more important than sanitary lighting and ventilation conditions."

The second paper of the general session was presented by Dr. Grover F. Powers, professor of pediatrics at the Yale Medical School, on "Some School Health Problems as seen in a Pediatric Clinic." This paper appears elsewhere in this issue.

The first of the sections was a discussion on teacher training led by Miss Mary E. Spencer, director of health education, Malden, Mass. She raised the fundamental question "What Can the Teachers' College Do for Better Health Education?" and made the following points:

1. The American Public Health Association in its recent conference has set high standards for School Health Education.

2. The roots of the school health education problem go out into the community. The community has discovered the teacher, now it is time for the teacher to discover the community.

3. School health education has not been effective because of the apathy of school administrators, the cleavage between theory and practice, the lack of unanimity as to the meaning of health education; and because much has been superimposed from without through such organizations as the W. C. T. U., social welfare groups and legal pressure.

4. New courses are not necessary in the Teachers College but a reorganization of material which will give pre-service emphasis on sociological problems, dynamic psychology and an understanding of the child. More workshop courses are important, using the students' own situation as one starting point.

5. In-service training cannot give the necessary scientific background for adequate nutrition teaching but conferences such as these, with refresher courses are necessary for the continuation of the program.

(The rappoteur may perhaps note the fact that this point in Miss Spencer's program obviously calls for the employment in Teachers Colleges of specialists trained in the field of hygiene, now generally absent from the staff available.)

The second section, dealing with the relation of physical education to the other phases of the school

health program, was led by Dr. C. C. Wilson, professor of health and physical education at Teachers College, Columbia University. Dr. Wilson outlined the following general goals of the school health program. The child should graduate (1) free from physical defect; (2) as a well nourished individual; (3) as an individual with sound emotional health; (4) well adjusted socially; (5) with established health attitudes. To attain these ends a child must be protected from disease and accidents; he must be provided during the school life with a healthful environment; he must be given the advantages of well planned health guidance; and treatment facilities must be available for the remedying of those defects which are found. Health instruction in our schools, according to Dr. Wilson, is in need of marked improvement. It is too often a traditional memorization without broad vision or human interest. It should be based on a child's study of his own self and his own home community; and should provide an answer to the question, "What can be done about it?" It is of special interest to note that the trend in education seems today once more to point toward a systematic course in hygiene occupying five periods a week for one year rather than information sprinkled through the school day. To provide such instruction is the difficult problem and this problem can only be solved by a specialist, who is both competent and enthusiastic. In addition to classroom instruction in hygiene, the health status of the child is profoundly influenced by the program of physical education, by the physical and emotional quality of the school environment and by the health service provided for the detection and remedying of defects. All of these should be knit together and integrated in a well-rounded health program.

The third section dealt with education for the physically handicapped and was directed by Miss Mabel A. Brenn, supervisor of physically handicapped, State Department of Education, Hartford, Connecticut.

1. Miss Brenn first outlined the services provided by the new 1943 law for the education of the physically handicapped in Connecticut as follows: Educable children between the ages of 4 and 21, inclusive (excluding those with eye and ear defects) are entitled to at least 5 hours a week of concentrated teacher time, suitably distributed according to the needs of the individual children. Their educability is to be determined by mental tests administered by a trained examiner. Their physical status is to be certified by a doctor's recommendation which states the amount of education the child is able to use. The extension of the age limit to 21 years gives time to complete a high school or suitable vocational training in spite of loss of time or retardation because of illness.

2. Methods by which the provisions of the law can be met include home teaching, special transportation to a local school, or classes for crippled children. The class for handicapped children may be established by the petition of the parents of 7 crippled children. It may need the services of an attendant as well as a specially trained teacher. The attendant's duties may be needed for the care of particular physical needs, preparation of diets, special exercises, medicine, etc. A class is desirable because it gives a child an opportunity for success, competition and social contacts which he misses during illness or home teaching.

3. Terms of state reimbursement. The town which supports a program for the physically handicapped may be reimbursed up to $200 per child beyond what is usually spent per child, or up to $300 per child if several towns cooperate. The money may be used for teachers' salaries, attendants' salaries, lunch programs, special therapy (physical or occupational), special equipment such as chairs, cots, mats, trays, etc., but not for changes in buildings.

Special grant forms are provided by the state and one should be submitted at the end of each year when the town is eligible for reimbursement.

The fourth section dealt with dental health under the direction of Dr. Ira D. Beebe, chairman of the Council on Dental Health of the Connecticut State Dental Association. Dr. Beebe pointed out that the incidence of dental disease is a vast problem throughout the state, and that the lack of adequate facilities and manpower at the present time seems to preclude any very satisfactory program of control. Dr. Beebe urged in the future a broader community approach and an intensive study of the pertinent factors involved. The things that may help in the future are:

(1) Possibilities of control of dental decay by the administration of fluorides either through water supply or by topical application;

(2) More extensive and intensive development of the Service of dental Hygienists;

(3) The institution of a system whereby children could visit the dentist during school hours.

(4) Elimination of all factors which tend to stig-

matize the indigent child in relation to the obtaining of medical care.

Dr. Harold N. Mitchell, district health officer, Lower East Side Health District, New York City, discussed Periodic Health Examinations and Follow-up Procedures. Dr. Mitchell pointed out the close relation between the work of the school physician and that of the private physician, and the importance of clarification of health findings for parents and physicians alike. He emphasized the need for:

(1) The allowance of adequate time for a really competent health examination as more important than the repetition of examinations at frequent intervals;

(2) The great value of concentrating the work of the school physician on selected cases picked out by the teacher. Dr. Nyswander's study in New York has shown how extremely fruitful this procedure is;

(3) The vital importance of having parents present at the school examination where findings are discussed;

(4) The desirability of keeping records following the individual child from the preschool through the school period;

(5) The necessity for a close relationship between the school physician and the family physician and for explanation of the program to the local medical society;

(6) The selection of a school physician of high quality—a process facilitated by the recent standards of qualification for school physicians issued by the American Public Health Association.

# METHODS OF EVALUATING SCHOOL HEALTH PROGRAMS

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FOUR MILLION of 13,000,000 young men of the nation have been rejected as unfit for military service because of some mental or physical deficiency—that is how the medical groups in the Selective Service system have evaluated the results of all our combined child health services for the last two or three decades.

Such an overall evaluation, as disconcerting and startling as it is, can be viewed only as a measurement of the results obtained from the several protective health services including prenatal care, infant and preschool health supervision, the school health program and any other community health services. The data serve quite well to point out that our activities designed to maintain the health of our youth have not been as effective as we believed or hoped, or as they should have been. But these results do not provide any direct cues for obtaining any better results. They do not reveal where the fault lies—with our parents, our schools or our community organizations. Nor do they answer any questions such as: "Why have we not been more effective? How can we improve? What activities need strengthening? What are we doing that should be changed? Is some new activity needed?"

Answers to detailed questions as to "why" or "how" to improve require a thorough analysis of everything that is done by schools and other agencies to assure healthy stalwart children. Let us, therefore, examine some of the ways in which an evaluating analysis may be made. This analysis will deal essentially with the school's contribution, since that is the subject of primary interest to this group.

In any program as complex as the one devoted to school health work, it is necessary to evaluate each activity separately to ascertain where improvement is possible. Later, it is also necessary to evaluate the interrelations of the parts to determine whether an effective synthesis of the several activities has been made. We shall, therefore, consider methods of evaluating each of the three major phases of the school health program, health service, health instruction, and school sanitation and then suggest methods of evaluating the interrelations of the three phases.

Among the complicating factors in the health service program are, first, the large number of persons concerned with the health of children; and,

*Given at the Second Wartime Conference on School Health Education, New Haven, October 6, 1944*

second, the variety of interests and professional skills involved. There are the parents; the teachers; the school physician; the nurse; the family physician; and, in many instances, a dentist or a specialist such as an otologist, ophthalmologist or orthopedic surgeon—not to mention the child himself. With so many and such a variety of people participating in a program focused on a single objective, there are many opportunities for slips—omissions, mistakes, or doubtful practices—that permit the alibi game of buck passing. How many times have we heard, ". . . if only the parents would do what they should," or ". . . if the teacher knew enough about the condition and would help in the follow-up," or "That school doctor is no good . . . he is always finding conditions that need no attention."

Our methods of evaluation must try to find out why there is need for any excuses. They must find out what part of the complex sequence of procedures, necessary to identify children with specific medical needs and then obtain medical services for them, is not functioning. Such appraisal is especially important, because, unless the child really receives the medical attention he needs, the entire effort put into the health service program, including observation by the teacher, examination by the physician and the follow-up, is completely wasted.

Too often school health programs have overlooked this fundamental truth—one that is so obvious it seems too trite to mention. As an example, witness the many programs and even legislative enactments that require an annual *examination* of specified grades or frequently, of every school child. However, so far as I know, there is no state that requires by law, or any program that even approaches the goal of seeing that every child actually receives the medical service that a medical examination has shown he needs. There is probably no community in the country with sufficient school health personnel to approach perfection in this respect; but even with present personnel, wouldn't it be possible to change the emphasis in the program so that more of the effort available could be expended in medical attention and less time and effort spent on examinations? Perhaps we might at least *aim* at the goal of having every child receive the medical attention that an examination indicates he needs. If that goal were made the main focus, there would be less effort devoted to examinations whose findings are only recorded with nothing else done about them.

Evaluating all the different procedures that go into achieving such a goal and deciding the relative emphasis to be given each procedure are certainly potentially fruitful activities. "But," say some, "how do you do it?"

The American Child Health Association developed a general methodology for such a survey in its study, "Physical Defects—the Pathway to Correction." It showed how an intensive investigation of what had been done for specific children could be analyzed to find the places where the program was weak and where, in the language of the study, cases were shunted from the "Pathway to Correction" or medical attention.

Nyswander developed this methodology to a high degree in her work on "Solving School Health Problems." Each step in the program was submitted to an objective evaluation and procedures that were unfruitful were discarded, and new and effective ones developed. No situation was too insignificant to be looked into. Even the effectiveness of the wording of various types of notes sent home to parents as well as who signs them were submitted to test and the results evaluated.

In each case the evaluation method was set up to answer a specific question, such as:

Do the records contain sufficient information to insure an understanding of the medical needs of the children?

Why are so many medical records of children who change schools misplaced? Where do they go?

Why are there so many disagreements between the school physicians and private physicians in their examination findings? What can be done about it?

One could continue indefinitely but in each case the general procedure was the same.

1. A breakdown in the service was detected or the origin or source of a problem was located.

2. The problem was broken down into parts so that each part could be submitted to experimental analysis.

3. Data were collected that would evaluate each separate detail of the activity under review. Sometimes the information was the presence or absence of some information on a record. Often interviews had to be conducted. Occasionally experiments had to be set up and the results appraised.

4. Once a solution was reached, the administrative application was tried out in a small area, before extending changes to the whole system.

5. Training, supervision, and group work with the

personnel were always used in installing new practices.

Nyswander not only perfected the general methodology for experimentally building effective programs, but she also demonstrated the importance of considering even what seem to be only tiny problems. She proved that in this field too, "A chain is no stronger than its weakest link." Most workers in school health work have considered evaluation as an estimate of the program as a whole. They have usually felt that it was an activity carried on by an independent group and only done on special occasions. In her detailed studies of various minute but related steps in the school health service program, Nyswander showed that continuing objective measurement of various alternatives of procedure markedly improved the effectiveness of the total program.

Overall evaluation is important and should be done from time to time, but workers need not wait for such special studies to ask themselves, "Am I carrying on my job in the most effective way possible?" However, one should not jump to hasty conclusions or change too quickly. Each contemplated change in procedure, no matter how minor, should be studied thoroughly to be sure that it will produce the desired results or be economical of effort before it is accepted. Setting up the type of experiment or developing the kind of data necessary to prove the superiority of any new procedure is a technical task, and those who undertake such studies should seek advice of those skilled in experimental method in order to make sure the results obtained can be interpreted in terms of practice. This should not deter workers from reviewing their programs and locating procedures that might be improved through experimentation. After all, as one of our Public Health Service officers once said, "Progress is made only by those with inquisitive minds."

Turning to the health instruction program, several overall evaluations on specific subjects have been made by various Public Opinion Polls. The most extensive measurement was the study of "What the Public Knows About Health," covering in all 100,000 people of various ages tested at the New York and the San Francisco World's Fairs. The finding of most concern to this group was that students over 17 years of age are poorly informed about practical facts—those that have a bearing on their own health such as the combination of foods most nutritious, susceptibility of youth of that age to tuberculosis, and that venereal disease cannot be cured with a few treatments—while at the same time they are well versed on facts of physiology and anatomy, such as that hormones are manufactured in the ductless glands, or that the blood fights germs by means of white corpuscles—information that has little application to daily living. Such an evaluation raises several questions. For example: Are our courses in biology, general science, and health education giving too much emphasis to physiological and anatomical information and not enough to instruction in the actual care of the body? Knowing where hormones are made, or the purpose of white corpuscles may be important but will it help one to be more healthy than he would otherwise be? Can we assume that a student armed chiefly with the basic definitions and relationships of a science will make the proper application of his knowledge if he has had no practice in the method of doing it? Is it not possible or even very likely that our health instruction has focused too much on imparting facts and not enough on how to solve health problems?

Perhaps what is needed in the health instructional phase of our program is a redefinition of goals. So long as the main purpose is to impart information methods of evaluation are simple. But measuring behavior attitudes or facility in meeting new health problems is much more difficult. Unfortunately, very little work has been done along this line. A tremendous opportunity for valuable contributions to methodology of appraisal is open to anyone who can find ways of measuring the success achieved with instructional programs.

On the evaluation of school sanitation, no recent extensive study covering the country or any large part of it is available. From such data as are available it would seem that Connecticut has made as much or more progress than any other State. With the "School Building Code" that provides a general statement of principles covering design, construction and operation of school buildings, and its use throughout the State, real progress has been made. Practically all schools are served by public water systems and the number of schools with outdoor privies is extremely small. This is very much better than the situation in one state in which at last count, there were 1,500 schools without any sanitary toilet facilities at all. There is, however, still room for improvement, and there is also the opportunity for the sanitation appraisal to be made as a part of the instructional program, or even expanded to the development of a study of home sanitation by the students.

How can one evaluate the coordination of these three different phases of the program? What are some of the items that need to be studied?

First of all is the *staff*. No program is better than its staff. One needs to evaluate the adequacy of the staff to do the job that is to be done. This appraisal means more than the number of degrees they hold, the number of organizations they belong to or the length of experience they have had. It means a real check of activities they perform. Nyswander showed that a time analysis check list through observation of the work of school nurses uncovered innumerable places where only a small change brought about marked improvement in effectiveness. Stenographic notes of instruction, history taking, supervisory remarks, of individual advice to parents carefully analyzed will uncover many inadequacies of interrelationship. Often the instruction is too meager, in too technical terms, or does not reach all concerned.

To what extent are the personnel keeping up with modern developments both in education and in public health practice? If some workers learn of newer procedures and want to make changes and others cling to the old practices, confusion is likely to arise. Perhaps the only technique for evaluation of the staff's progressiveness is to watch their programs and measure the degree to which agreement or confusion prevails.

Detailed following of cases including the information given parent, child, teacher, nurse or doctor and the use made of that information will evaluate the degree to which the activities of each dovetail with the other. Franzen developed the technique of asking various members of the school health staff identical questions of common interest about the same child. The degree to which they all had the same information measured the cooperaiton of the staff.

Another technique for evaluating the coordination of the program is the extent to which there is group planning among the personnel. It is not enough to have a staff meeting periodically, unless each member contributes to the listing of problems and to the working out of solutions. Group problem solving is difficult to accomplish but real progress will be made only when each of the several professional workers can learn to respect the members of other professions and recognize the contribution that each can make in the solution of the health problems of children.

Thus far we have described some of the phases of the school health program and suggested various techniques that might be used. I cannot close without a few words of caution.

The health habits and attitudes of children as well as their physical well being are quite difficult to measure. There is a distinct need for the development of more precise tools of evaluation. Until they are developed we must be careful to view our interpretations in terms of the crudity of the methods of measurement.

Children's health conditions and behavior are the resultant of many factors other than the school health program; interpretations of the results of any evaluation procedure must, therefore, be made against a broad background of social and economic environmental status. But despite the pitfalls of interpretation, we must not neglect evaluation; only by continuous appraisal and revision of our activities can programs remain effective.

# METASTATIC MALIGNANCY TREATED BY RADICAL METHODS

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MALIGNANT disease is a complicated problem in management even when it is localized to the tissue of origin, and when it has metastasized or extended to distant structures radical treatment for practical purposes is useless. The following two cases which were presented recently at the New Haven Hospital Tumor Conference both fortunately lent themselves to radical management of distant metastases and seem worthy of further discussion:

Case I—F. S., a 42 year old white man was admitted to the New Haven Hospital on February 2, 1932, complaining of pain in the right flank and a loss of 20 pounds in weight in the previous four months. Five months before admission the patient began to have irregular attacks of intermittent, dull, aching and non-radiating right-sided abdominal pain. The attacks lasted four weeks and then disappeared until seven weeks before admission when they recurred and were more intense. There had been one attack of vomiting three days before admission. There was no change in the bowel habits. Past and family history were irrelevant. The important findings on physical examination were limited to the abdomen where there was a mobile, tender mass in the right abdomen, 6 cms. in diameter, that extended downward from the costal margin. It did not move with respirations. The red blood cell count was 4,570,000, hemoglobin was 77 per cent of normal and the white blood cell count was 12,040. The urine was negative. The stool showed occult blood with the guaiac test on three different occasions. A barium enema showed a primary tumor in the ascending colon. A diagnosis of carcinoma of the caecum and ascending colon was made and on February 10, 1932, a right colectomy was done by Dr. S. C. Harvey. The postoperative course was uncomplicated, and the patient was discharged from the hospital on the twenty-first postoperative day. The pathological diagnosis was adenocarcinoma of the caecum. The regional lymph nodes were not involved.

The patient was readmitted to the hospital on July 17, 1933, complaining of a dull aching pain in the left upper quadrant of the abdomen of six months duration. It was aggravated by forward bending and relieved by lying on the right side. The important physical findings were again limited to the abdomen where there was a firm, smooth, tender mass attached to the left anterior costal margin. X-rays of this vicinity were negative. On July 18, 1933, an exploratory laparotomy was performed by Dr. A. W. Oughterson, and a mass 9 x 11 x 7 cms. in size was found in the left anterior abdominal wall underneath the costal border that also involved the costal cartilages and diaphragm. To remove it it was necessary to include portions of the peritoneum, posterior rectus sheath, diaphragm, pleura and the sixth, seventh and eighth costal cartilages. His postoperative course was again uneventful, and the patient was discharged on August 30, 1933. The hospital stay was prolonged to obtain firm healing of the defect in the abdominal wall. It has been necessary for him to wear an abdominal support, but he is well without evidence of recurrent disease eleven years after the second operation. The pathological diagnosis of the tumor removed at the second operation was metastatic adenocarcinoma in the diaphragm. The microscopic sections have been reviewed and compared with those prepared from the tumor in the caecum. There is a marked similarity, and undoubtedly the second tumor is a metastatic deposit from the first.

Case II—(This patient has been reported in detail elsewhere* and therefore will be only briefly reviewed here). J. B., a 65 year old white woman, was admitted to the New Haven Hospital on April 5, 1943, complaining of a hacking cough for six months. For five months she had had bright red blood in her sputum. Family history was irrelevant. A noteworthy fact in the past history was a hysterectomy done at another hospital ten years previously. The diagnosis was carcinoma of the uterus, presumably made on gross examination since there was no pathologist at that hospital at that time, and no microscopic sections were made. Physical examination was essentially negative except for the right chest where there was dullness to percussion anteriorly from the third rib to the base with diminished breath sounds. The roentgen diagnosis of the x-rays of the chest was carcinoma of the right upper and middle lobes. Bronchoscopy showed slight puckering of the mucosa around the right upper lobe bronchial opening. On April 17, 1943, a right total pneumonectomy was done by Dr. G. E. Lindskog. The postoperative course was uneventful and the patient was discharged from the hospital on May 23, 1943. The pathological diagnosis was adenocarcinoma of the uterus, metastatic to the right upper lobe of the lung. The patient is alive and well at the present time.

*Brezina, P.S., and Lindskog, G. E.: Total Pneumonectomy for Metastatic Uterine Carcinoma. J. Thor. Surg. 12:728-733, 1943

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*This investigation has been aided by a grant from The Jane Coffin Childs Memorial Fund for Medical Research*

DISCUSSION

It was not known that either one of these patients had metastatic disease when the second radical procedures were carried out, and it is conceivable that neither one of them would have been performed had that information been available. However, both results have been highly satisfactory and even though both patients should succumb to their diseases the palliation obtained has been remarkable.

One seldom has the opportunity to treat distant metastases radically, but if it seems that all of the local disease can be removed, the attempt may be well worth the effort. If a given lesion seems to be a metastatic deposit and if radical surgery is contemplated, every measure available, such as thorough x-ray studies, should be employed to determine whether other deposits are present. Usually, if multiple metastases are present, radical surgery is not warranted but occasionally sufficient palliation will be obtained by the removal of a single offending lesion to justify the time, expense and danger of the procedure.

# NARCOTHERAPY IN HYSTERICAL REACTIONS

## The Intravenous Use of 2.5% Pentothal Sodium Solution

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Certain hysterical reactions present diagnostic problems and treatment difficulties. Also, they may become chronic, disabling and demoralizing. Experience with hysteria, especially the conversion type, points to the need for early and positive measures . . . to secure rapid return of normal function and to prevent the laying down of a chronic abnormal pattern. The chronic state is difficult to treat, may already have superimposed organic changes (atrophy, ankylosis and contractures when joints and muscles are involved) and often will lead to undesirable affective changes such as depression and withdrawal. In time, there is a clinical picture of a serious dissociative process which disrupts the patient's entire life. It is therefore urgent to speedily recognize hysteria and to treat it vigorously.

Although no standard therapy has been developed owing to the varied and bizarre nature of these peculiar reactions, the value of narcosis as a psychiatric aid has been known for some time . . . Bleckwenn,[1] Horsley[2] and others. Since 1939, the author has used intravenously induced narcosis in several unusual cases with gratifying effect. Garofalo, assistant in the original case,[3] has reported two recoveries of his own by the same method.[4] The treatment may be used secondarily to explore unconscious content but its primary purpose is to bring about a quick clinical recovery and to return the patient to a useful status.

Thinking about hysteria poses numerous questions . . . What is the dynamism? What personality types are vulnerable? Why does it involve the eyes? The hand or the legs? What happens to disturb the physiology of conduction of impulses? How does recovery take place? These questions are difficult to answer in a manner which will satisfy all the workers in the field. However, it seems reasonable to postulate that the conversion reaction is the result of an intolerable situation which is irritating, annoying and trying . . . which builds up emotional tension beyond endurance and finally exceeds a threshold . . . and crashes through in an altered form as hypesthesia, anesthesia, paralysis and tremor. For some time, the author has suspected* the physiologic possibility of altered, blocked or short circuits which would explain the clinical phenomena and which would also explain recovery following narcotherapy, i.e., the relief and restoration of these circuits. Foster Kennedy supported the theory of disturbed circuit during a recent lecture[5] and Strecker[6] supports the opinion that hysteria represents unresolved emotional conflicts which are no longer tolerable. Whether or not

*This is an independent concept without claim to priority

there exists an area of predilection and the relative strength of the psychoanalytic concept vs. the theory of locus minoris resistentiae are problems beyond the scope of this paper.

Before instituting treatment, it is necessary to do a careful physical examination with special attention to the area involved . . . even when hysteria is suspected early. Also, the use of intravenous drugs should be made with caution. The value in having an anesthetist as an assistant whenever possible is clear. In addition to preparing and administering the solution, he is familiar with all the contra-indications, untoward reactions, resuscitative measures and can be relied upon in event of difficulty i.e., resistiveness by patient, laryngospasm with fit of coughing and cyanosis. It is advisable to keep a small tank of oxygen outside the patient's room and to have handy several stimulants for injection. The incidence of trouble in the author's experience has been almost negligible. Also, it is advisable to record the questions, answers and other events of interest and enter these later in the hospital chart. This is done by a nurse who occupies an inconspicuous place in the room. At no time is anything done to alarm or intimidate the patient and no remarks are made to belittle him or to suggest the existence of some mystical condition. The patient is treated as if he actually had "paralysis" and his questions are answered directly and honestly. A sympathetic approach will gain his confidence and remove any suspicion of the treatment but if this should develop, the patient is told that he is going to receive an intravenous medicine to relax him. Usually, this is sufficient.

20 cc. of 2.5%pentothal sodium solution is placed in a syringe, the patient's arm is extended comfortably on a board and 2 cc. is given fairly rapidly. As light sleep is being induced, the therapist gauges the subject's response to the drug and keeps the assistant posted on how much of and how often he wants the drug given. About 1 cc. every 90-120 seconds suffices. One strives to maintain the patient midway between being awake and being asleep so that he will respond to stimuli without offering resistance. After treatment has been started, the therapist is more or less "on his own." His efforts are directed toward restoration of normal function of the impaired part. This may be done immediately or gradually while the patient is engaged in conversation. If there is aphonia, then the goal becomes the return of voice and if the patient is unable to move his foot, we try to make him do so by suggestion, persuasion, encouragement and finally by mechanical stimulation (tickling, scratching, pricking, pinching, etc.). The therapist must be courageous, persistent, inventive and should enjoy self-confidence to a reasonable degree. Sometimes, various methods must be applied and continued in spite of discouraging results until success is achieved. Psychiatric training and insight are of great help in the approach to and understanding of the whole problem.

Case 1—M. McC., a single girl of 16, well adjusted and of high intelligence complained of aphonia of 3 months duration. In September 1938, patient laughed heartily while being tickled by her sister and later developed a cough which persisted until March, 1939 when her voice disappeared. She stopped going to school, became depressed, withdrew from her varied social outlets and friends . . . lost interest in life. Physical findings were normal except for mitral murmur and cardiac enlargement from rheumatic fever. Larynx was normal. On May 18, 1939 patient was admitted to the Hartford Municipal Hospital for treatment.[3] Pentothal sodium solution 2.5% was given slowly by vein to keep her in an hypnotic state and conversation was attempted. This failed and was followed by stimulation of the pharynx by a local irritant which also failed. After 9 cc. were injected over a period of 25 minutes and nothing happened, it was accidentally observed that the patient was unusually sensitive to stimulation by scratching of the soles of her feet. In due time, she found the stimulation unbearable, kicked her feet violently and cried out "please stop!". Treatment was stopped immediately, patient sobbed for a few moments with much feeling then calmed down and seemed genuinely pleased to have her voice again. She was very anxious to make up for lost time and it was necessary to station a nurse at the bedside to insure careful use of the vocal cords. At first, there was weak scanning speech which slowly gained in tone and volume each day. Patient was discharged on May 21, 4 days after admission. Ten days after therapy, voice was normal and continued so to the end of 1942, our last contact with the patient. At no time was there revealed any traumatic event or situation which might have been considered significant in this instance.

Case 2—E. K., a single boy of 21, well adjusted until his 20th year at which time he ran away from home, became anti-social, committed theft, served time in jail and attempted suicide several times. This patient was brought to the Hartford Municipal Hospital by the police on December 31, 1940 with the history that he was injured when the stolen car that he was driving crashed into a telephone pole. Patient got out of the car, ran a short distance and collapsed after several shots were fired. The police found him unconscious. There were no bullet wounds. In the emergency room, patient was unconscious, restless and presented a small discolored hematoma in the left frontal region. The left pupil was increased in size and both reacted sluggishly to light. Blood pressure was normal, pulse 120 and temperature 100 F. rectally. The remainder of the physical including a complete neurologic examination was without significance.

Lumbar puncture and skull films were normal. Consciousness returned slowly but abnormal behavior developed. The patient lay quietly in bed, stared straight ahead as if in a trance, complained that he could not see except to distinguish light from darkness and smoked cigarets to the very end burning his fingers without sign of pain or concern. When his family came to see him, he did not recognize them in spite of his mother's entreating. His appetite was good and he ate by himself without spilling food. Although there were catatonic features in the picture, it was evident that we were dealing with a psychogenic process, probably hysterical conversion.

After an induction dose of 3 cc. of 2.5% solution of pentothal sodium was given into the vein, the patient fell asleep and was permitted to sleep for a few moments after which he was awakened by patting on the face and maintained in a twilight state on a dose of 0.5 cc. a minute. A pleasant conversation was carried on for a while and the patient volunteered a great deal of history about his unhappy home life, strictness of his parents, lack of spending money and worry over a girl friend who was disliked by his people. After 7.5 cc. were given, patient became partially alert and said that he could see light from a flashlight (which was being played on his face). He was then given the light and told to elevate the beam until it struck the intern's pipe (which was held in latter's hand about 3 feet above the foot of the bed). Patient did this perfectly, stopping when the light focused the pipe although he protested that he could not see. Suddenly, he became very tense, his face flushed, his neck structures bulged as he raised his head with great effort . . . then quickly, his head fell back and his entire countenance changed to one of peace and relaxation. Several post-hypnotic suggestions were made and treatment was terminated. The total time elapsed was about 40 minutes. Several hours later, patient could discern faces and objects and after 48 hours, his sight was practically normal. He became friendly with the other patients and seemed quite cheerful. He was discharged to the authorities on January 12, 1941 his 13th hospital day.

Case 3—E. C., a white male of 41 years was brought to the Hartford Muncipal Hospital by the police on January 18, 1941 with the report that he had fallen on the street, bumped his head and lost consciousness. In the emergency room, patient was alert and complained of pain in the left parietal region and loss of power in both lower extremities. He seemed sincere enough to make the house officer suspect transverse myelitis and the service was notified. Before one of the staff arrived, the intern already discovered normal reflexes and a sharply demarcated line of complete sensory loss from D XII down. Repeat sensory examinations showed bizarre shifts (markings were made with ink) both up and down which did not conform to anatomical distribution and were so variable as to prohibit any other diagnosis but conversion hysteria. Further, it was determined by casual questioning during the neurologic review that the patient had been under great strain since a social agency criticized his care of his children (mother was deceased) Also, patient showed no concern over his disability and behaved as if his legs belonged to someone else. By persuasion, he thought that he had a little feeling in his left leg and thought he might be able to move it a little . . . which he did with some effort. However, he was sure that the right one was useless.

Since the hour was late and no anesthetist was immediately available and since there was some reaction to persuasion, it was decided to give the patient intravenously a solution of sodium amytal. After 4 grains were administered, patient pulled his feet away from the sharp end of a pin and was then permitted to fall asleep. The next morning, he walked out of the hospital against advice and stated that he had had a similar attack several years ago from which he recovered without treatment . . . and that we had done nothing for him this time except to draw some blood from his vein.

Case 4—M. L., a comely lady of 42, educated abroad and extremely intelligent was admitted to the Mt. Sinai Hospital on March 27, 1941 with complaint of chest pain. For the next 2 weeks, she presented a severe productive cough for which she received considerable sedation. On April 11, patient stated that she experienced fleeting numbness in the left leg and on April 17, she had a 2nd attack . . . this time, there was complaint of combined loss of motor and sensory function from the knees down.

Inspection revealed immediately that there was something askew in her behavior. She was lying rather rigidly in bed, her eyes were shut tight and did not open on suggestion but instead began to tear and the lids fluttered. When asked to explain her feelings, she stated that she saw stars and a cloudy haze and heard bells in the distance. When helped out of bed to test her gait, patient stood up for a second then fell in a heap. The examination proceeded with great difficulty owing to a lack of attention and no interest. Findings were bizarre. Patient said that she saw double, called sugar salt . . . showed active tendon reflexes, spotty and variable sensory changes from the patellae down and weakness of both legs. The picture was quite confused in view of her behavior and the reliability of the findings was questioned. On April 20, patient lapsed into a depressive stupor and was given Last Rites at the request of her family. Later that day, it was decided to try narcotherapy with pentothal sodium, 2.5% solution, and during the course of administration of about 14 cc. a great deal of valuable information was gained. It was learned that patient was unhappy, lonesome, pining away for her mother in Europe, not in love with her husband and brooding over an old love affair which was unsuccessful. Also, she was able to move her legs freely and seemed most cooperative and friendly. Although she continued to be actively confused for several days and reacted to hallucinatory and delusional experiences, she gained in strength, asked for ice cream which she enjoyed and left the hospital on April 22 still weak and weepy but much improved. She was then followed at home for several weeks and made a complete recovery. It should be mentioned that during the pentothal treatment, it was discovered that patient had a similar attack of motor weakness in her adolescence but the facts were beyond recall.

Case 5—J. C., white male, 25, a big fellow with strong muscles, was brought to the Hartford Municipal Hospital by the police on July 28, 1943. He had been arrested 6 days earlier for alcoholism. While in jail, patient aroused suspicion by his peculiar behavior and observation was recommended. The history was as follows: Patient had been work-

ing in a coal mine in Pennsylvania until 4 months ago when he became dissatisfied with his job and left. At about the same time, he was rejected for service and also, was frightened by a dog and lost his voice. Since then, he was obliged to communicate his thoughts only by writing. Patient seemed well oriented but showed peculiar activity . . . grimacing, pre-occupation, silly grinning and entertained the nursing staff by smoking 2 cigarets at one time, one in each hand. He was good natured and cooperative.

Physical examination was normal. Patient was prepared for narcotherapy and 3 cc. of 2.5% pentothal sodium solution were given into the vein. Attempts at conversation failed. In view of the success by stimulation of the feet in the first case, it was decided to test patient's reaction to similar stimulation. He was found to be very sensitive to this whereupon, a safety pin was carried along the soles of the feet with the patient struggling to escape. After several minutes, he strained so vigorously that it was feared cardiac damage would develop and stimulation was halted for a few minutes while the patient rested. It was then resumed for a while . . . and after several such episodes, the patient finally exclaimed "Oh God!". Treatment was stopped, total time elapsed was 45 minutes, total solution consumed was 23 cc. Patient then remarked that the treatment was great, refused to stop talking and was discharged to the police on July 30, 1943, 2 days after admission.

Case 6—T. E. C., white male about 18, in uniform, was picked up by the police when he was found wandering about aimlessly and brought to the Hartford Municipal Hospital on July 4, 1943. There were no means of identification and the only vocal production by the patient consisted of "No, Yes. She made me eat. The girl." He was apparently referring to the nurse. Patient maintained a fixed posture, seemed to be in a daze or fugue, "frozen" and out of contact. He was given pentothal sodium solution, 2.5% by vein and conversation was attempted. His only replies were those above. There was absolutely no change in his behavior which remained stereotyped and withdrawn. It was our impression that the diagnosis was Acute Schizoid Episode in view of the clinical picture and absence of alcoholism and trauma. He was located by his unit 2 days later and left the hospital July 6, 1943. He continued to be confused and was given several electric convulsions with recovery although occasional pre-occupation in daydreaming was observed.

Case 7—Unknown Girl, about 16, white, was brought to the Hartford Municipal Hospital by the police on October 27, 1943, with the story that she had lost her memory that morning and was wandering through the railroad station. Physical examination was essentially normal. Psychiatric interview was difficult owing to resistiveness to questions and lack of interest. Patient refused to face the examiner and insisted that she had to find work. No clues could be obtained regarding her whereabouts except "I want to go to Texas." Patient was permitted to rest for a while and a 2.5% solution of pentothal sodium was prepared.

After 12 cc. were administered intravenously, she told a fantastic story about parental abuse, going to dance halls, abuse by teachers and a friend in Texas. During conversation, she named places which were known to one of the personnel and it seemed quite certain that she came from a nearby city. The police were notified and within an hour, her mother was on the way to the hospital. At first, patient refused to recognise her mother and insisted on remaining anonymous. The next morning, she recalled her mother's visit, seemed in full contact and was friendly and cooperative. Patient was discharged November 3, 1943, recovered. It was learned later that there had been considerable difficulty in adjustment both at home and in school.

## CONCLUSIONS

Hysterical reactions may appear in many forms. The conversion type is especially interesting in view of psychosomatic concepts. The mechanism of altered neurophysiology in these cases is not clear although the theory of disturbed circuits holds some appeal. That intravenous narcotherapy works successfully by reestablishing these circuits is one theoretical consideration. The term "dysemotio" is advanced as a logical substitute for hysteria.

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# PILONIDAL CYST

## A Report of Six Cases and a Comment on Treatment by Injection

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THIS IS a report of six cases of pilonidal cyst in private practice, two of which were operated upon and four treated by injection. All six cases were definite multitract pilonidal cysts and those operated upon were no larger than the ones treated by injection. From the quantity of material injected in the sixth case, this appeared to be the most extensive of all.

Case 1, 1932—E. F. Complete surgical removal after injection with gentian violet. The patient was in the hospital 15 days and away from work another 10 days. A large granulating wound remained after the operation for 4 months before it finally healed. It has never broken down since and has given no trouble.

Case 2, 1933—R. W. When first seen the cyst was infected and was drained under novocaine at the office. The base was cauterized with strong carbolic acid and the tracts followed up with sodium hydrate crystals on fine cotton swabs during the next few office visits. The wound healed and the cyst did not break down again until April, 1936. This time it had to be incised again and treated as in 1933. It healed as before, but in October, 1936, the patient returned, and as he would not consent to surgery, another attempt was made to rid him of his trouble and still keep him ambulant. At the time we were using sodium morrhuate for injection of varicose veins in a 5% and 10% solution, and it was also being recommended as a sclerosing agent for other purposes. A small opening was made, what pus there was drained out (about 4 cc.) and the nipple of a 2 cc. hpyo syringe inserted and under slight pressure 2 cc. of 10% sodium morrhuate injected. This caused but slight discomfort. This was repeated once more the next day, under much more pressure and caused severe pain. The cyst was probably very small as there was only one opening and with a fairly tight joint it would contain less than 2 cc. The patient reported for a dressing after three days and there was considerable inflammation, but very little drainage. He was not seen again for this condition, but he was a frequent patient for other ailments until September, 1938—a period of 5 years. The cyst did not recur during this time.

Case 3, 1936—This patient, a woman, was first seen at her residence and presented a rather large pilonidal cyst in an acute state of infection. It was drained and allowed to quiet down. She wished surgical removal so injection was not attempted. This was done, the patient being in the hospital for 18 days and spending about one week more of convalescence at home.

Case 4, 1936—H. D. A woman, presenting a pilonidal cyst with constantly draining sinus following an acute abscess which was opened a year previous. She did not wish surgical removal. The cyst proved to be extensive with three more openings, one inch inferiorly. After injecting the tracts with gentian violet, it was explored superficially with novocaine, removing the more gentian stained tissues and treating the deeper areas with carbolic and sodium hydrate. It seemed to heal well primarily, but in two weeks broke down again. This time the 10% sodium morrhuate was injected under slight pressure, placing a finger firmly over the three small openings which had not been removed at the orignial exploration. It was necessary to inject about 2 cc. to produce counter-pressure and pain. The use of pressure was not continued at the time of injection, a fault which will be commented upon later. Two more injections were made in the next two weeks after which the entire area broke down and granulated in slowly over a period of one month. There had been one day's loss of time during the entire treatment thus far. During the next two and a half years the cyst broke down four times and on each occasion the patient received one or two injections which was followed by prompt closure and a longer interval of complete relief. There was never any increased tenderness and no loss of time due to the treatment. From subsequent experience it is plain that the pressure should have been continued over a period of three to four minutes. Also, the removal of any tissue makes this type of treatment less effectual. The following cases demonstrate this point. However, this case healed firmly and has not broke down.

Case 5, 1938—C. S. A mongoloid woman of 24 years presented a draining sinus of two to three weeks duration following occasional complaint of discomfort over a period of one year. The parents did not wish surgical removal due to the patient's mental condition. The patient was very cooperative as an office patient. There was but one drainage tract about the level of the sacro-coccygeal joint and to the left of the midline. It was ampulla-like and the nipple of a 2 cc. syringe made a tight joint. 10% sodium morrhuate was injected under pressure twice at two-day intervals and patient was not seen again for one month. At that time the deep tracts were apparently obliterated but there was a moderate sized superficial, rather rigid pocket that did not yield to treatment with the injection which was done about

every two months for five more months. In the meantime the patient had no disability and was able to go without a dressing most of the time. Finally, under novocaine, this superficial pocket was opened and one deeper tract was exposed. The entire cavity was packed with 10% sodium morrhuate gauze. After this there was no more trouble. It granulated in and healed firmly. This was apparently a fairly extensive cyst and the first two injections must have obliterated the deeper tracts. Probably with more frequent injections the entire cavity could have been obliterated readily early in the treatment, but it was difficult to have the patient brought to the office.

Case 6, 1942—S. S. A man, presenting an abscessed pilonidal cyst apparently very extensive with two satellite openings. After the pus was completely drained out and inflammation beginning to clear up, treatment with 10% sodium morrhuate was started. The first injection was 1 cc. He seemed to suffer more pain than the other three cases. Another injection of 2 cc. the next day did not nearly fill the original cyst. The other openings soon showed abscess formation and each of these were injected in the same way. One contained over 4 cc. The patient was called up by the Selective Service Board and accepted two months after the last treatment. The lesions had healed and even the induration which was first noticed was gone.

DISCUSSION

A treatment of pilonidal cyst is outlined which can be carried out entirely as office treatment and which has been employed in four cases with complete cure and with almost no loss of time for the patient. In the earlier cases there was a long interval between the start of treatment and the cure. However, certain observations suggest that further refinements in technique will materially hasten the desired result.

SUMMARY

Six cases of pilonidal cyst are presented from private practice. Two were treated by surgical removal which entailed three to four weeks' loss of time and the expense of hospitalization and operation. Four were treated as office patients by injection of 10% sodium morrhuate. There was one day's disability in one instance and about six days' disability in another. This experience would indicate that a marked shortening of the treatment in these cases can be effected.

# THE PSYCHIATRIC PROBLEMS OF THE RETURNING SOLDIER AND THEIR MEDICAL MANAGEMENT

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I HAVE pleasantly anticipated this opportunity of meeting with you, remembering your distinguished inheritance as physicians of New England, and of Connecticut in particular. You and your medical forebears have for years exerted leadership in mental medicine. One of the thirteen organizers of The American Psychiatric Association was Dr. Samuel B. Woodward of Torrington, Connecticut, and The Connecticut Medical Society was responsible for the existence of The Hartford Retreat, now one of the outstanding psychiatric hospitals in the United States. You will remember that the Mental Hygiene movement originated in Connecticut, nursed in its infancy by a few far-seeing medical men. And it was in Connecticut that the first Institute of Human Relations was established in connection with the Yale School of Medicine. I remind you of these accomplishments knowing that you will now retain this leadership in a medical situation requiring your urgent attention.

Recent authoritative literature describing the psychiatric problems of World War II in Great Britain and in the United States has been reviewed as a prelude to this discussion. Additional information has been obtained from the chiefs of the divisions of psychiatry of the United States Army and the United States Navy, the Director of Selective Service, the Director of the Veterans' Bureau, the Red Cross, the National Committee of Mental Hygiene and the Superintendents of the three Connecticut State Hospitals. They have all been most cooperative and I particularly wish to thank Commander Braceland of the United States Navy and

Colonel Menninger of the Surgeon General's Office for making available all information permitted by the Joint Security Board. This data has been collected in an effort to present to you as accurate a picture of the situation as is possible under the circumstances.

It is a recognized fact that Selective Service examinations, together with military training and combat duty, have collectively uncovered an amazingly large number of men with psychiatric problems. Selective Service alone has rejected around a million men for this reason; the military forces have discharged over 400,000 psychiatric cases, and in addition have a large number of such cases under observtaion at this time. Both of these figures are estimates, but they are approximately correct. The treatment of these men is to date the biggest medical problem of this War. The fact is, most of them will not be adequately treated unless they are cared for by civilian physicians, assisted by all the supportive social factors in the community.

It is the purpose of physicians in the military services to restore men to full duty or if that is not possible to separate them from the service and return them to civilian life to be treated either by the Veterans' Bureau or civilian physicians. However, actively psychotic patients are not returned to civilian life until they are considered no longer a risk to thmeselves or the community.

The cases which have been uncovered by Selective Service as well as those activated and caused by military service are thrown back, so to speak, into our laps, and it is the family doctor who in most instances will ultimately have to carry the responsibility of caring for them. This problem is too big for the Government to handle, and we know from similar experience following the last War that if the Government tries to care for these patients, after discharge from the Army, that the results will be unsatisfactory. The practice of medicine is based on an individual relationship existing between doctor and patient—this necessary personal emotional transference cannot exist between a Government Bureau and patient. Therefore, it will be the job of civilian physicians, who know these men and are familiar with the facilities of the communities in which they live, to readjust them to civilian life.

Mention has been made of the unexpectedly large number of psychiatric cases which have been found. In this connection it should be remembered that the War suddenly magnified and precipitated most of the psychiatric problems among men of draft age. Without the War some of these difficulties would never have been discovered and others would have developed gradually. The causes behind the sudden precipitation of the problem are obviously the screening process of Selective Service, the acute emotional factor of fear, confusion in life purposes, dislike of military life, injury to ego and pride, and the general loss of emotional control engendered by war hysteria.

Fortunately we are not going to have to treat all of these two million or more men who will by the end of the War have been diagnosed as psychiatric problems. The majority of them will readjust after a fashion without medical assistance. However, there will be a large number who will need help. These can be divided into two groups; those who obviously need assistance shortly after discharge, and those who are found to need such help only after months have passed and it becomes evident that they are having a difficult time readjusting to civilian life. The majority of the latter type of cases will develop slowly. The men will seem to be well when they first come home, but their difficulties will gradually accumulate and become noticeable.

The treatment of most psychiatric cases is so time consuming that physicians must have assistance in treating these ex-service men. To accomplish this, there should be organized in each community a group of able and responsible citizens, including doctors, preachers, lawyers, social workers, and women of ability, who are trained and stand ready to assist these men. Experience with civilian defense and volunteer nursing has indicated that much talent goes to waste in each community; this talent could well be used now along lines of readjusting soldiers to civilian life. A group of able, trained laymen working in each community would be of great assistance to the doctors in treating the soldiers with psychiatric problems.

In many communities group therapy of ex-service men can be employed. By group therapy is meant the psychological re-education of a group of patients through lectures given by a physician. Such group therapy must be supplemented by a few individual interviews. Group therapy makes it possible to care for more patients with greater ease, decreases the demand on the doctor's time, and the group spirit aroused by group therapy is of great value in such treatment.

In order that all of this may be properly organized,

the Federal Government should be requested by our medical societies to establish a method for coordinating medical rehabilitation in each community, patterned somewhat after that of the Office of Civilian Defense.

As physicians we are reasonably familiar with the nature of the psychiatric problems of the ex-service man with which we shall have to cope. These can be summarized as follows:

1. *The psychiatric problems which were uncovered by Selective Service screening.* This screening process at the Induction Lines probably discovered one half of the potential psychiatric cases; the Army in the course of military training and combat duty discovered another fourth; and of the remaining fourth, potential psychiatric cases who went through the War in good health and were excellent soldiers, some will probably break down later and attribute their illness to War. The Selective Service psychiatric screening was effective as far as it went, and it did not reject many men who were fit for combat service, contrary to recently published sensational misinformation. Many of the men who were rejected have since been carefully re-examined by civilian psychiatric members of medical advisory boards, with the result that very few selectees were returned to Induction Lines for reconsideration.

The *discovery* by Selective Service that these men have psychiatric problems was in itself a serious matter. Many of them were getting along reasonably well in the community before they were rejected and now quite a few suspect that something is really wrong with them. Most of these men did not know that they were potential psychiatric cases, and in many instances the family did not suspect it. As a result of rejection a large number of these individuals have suffered a trauma to their ego, some are frightened, confused, ashamed and angry, and all of this is in addition to their fundamental instability. It has been said that mental health is to a certain extent a matter of personal opinion; certainly if a person with a purely functional difficulty believes he is going to get along all right he usually does. But once an individual has acquired an idea that he is unwell, or is different from others, his ego does not sustain him in periods of emotional and physical stress; he has lost two important mental assets—courage and pride. If these men are not to be permanently weakened by being rejected for military service, some way must be found to rationalize the situation for them and for their families.

2. *A large number of chronically slow adaptors,* who exist in every community, have had their lives seriously disturbed by being removed from their habitual environment and subjected to military training. The degree of adaptability a person possesses varies with the individual, and is in all instances a gradual process. As children develop they fit into their environment gradually, assisted by friendly adults and helped by a society which more or less adjusts to them. The social structure stretches here and there to make room for an individual's odd corners and peculiar angles. As a result of this gradual process of personal adjustment and social accommodation, individuals become somewhat accustomed to one another and learn to live together. The military authorities took these slow adaptors out of their accustomed niches, trained them in ways of living not in keeping with civilized society, and deprived them of considerable initiative by teaching them to wait for orders and to pass the buck. The more adaptable individuals will not suffer so much from these experiences but the poor and slow adaptors will find it difficult to return to society on any such level as they had gradually attained before being inducted into the service. These slow adaptors will need patient, tolerant, kind and understanding assistance. Remember that while they are slow adaptors, many of them will become useful, loyal and beloved citizens. A slow adaptor is like a tree inasmuch as once either gets its roots down it does not move around much, and one usually knows what to expect of it.

3. *The frankly psychotic individual.* As before stated, the military services do not as a rule return frankly psychotic cases to civilian life, but unless their condition is quite serious they get back sooner or later. Since they are young men most of these will be cases of schizophrenia and manic depressive psychoses. They are rather easily recognized and the majority will be cared for in federal, state or private mental hospitals. Many borderline cases will be returned from military service to civilian life who will later develop more pronounced symptoms, hastened by their inability to adjust to civilian life. Up to this time there have been one hundred and sixty-five veterans of World War II treated in Connecticut state hospitals.

4. *Psychopathic personalities without psychoses.* These are society's chronic misfits and their number is legion. Some of them were a source of difficulty before they went away to War, and their aggres-

siveness having been increased by military service, they will be more of a problem when they return home. They are impulsive, aggressive, unreasonable, have poor judgment, are frequently cruel, are given to excesses, are irresponsible, have little respect for property or the rights of others, do not sustain constructive emotional attachments, have a tendency to associate with inferiors, steal, lie, drink, indulge in sexual excesses or irregularities, and are a constant source of trouble to themselves and the community. They are likely to meet a violent death by accident or to spend much of their lives in hospitals, corrective or penal institutions.

5. *The Neurotic Personalities.* The life histories of people suffering from psychoneuroses indicate that some of these individuals are handicapped by a constitutional neurotic tendency. They persistently react to the stresses of life by evidencing regressive neurotic reactions such as neurasthenia, hypochondriases, anxiety states, reactive depressions, phobias and compulsions. They were difficult babies, many had feeding problems, were bed wetters, nail biters, were unduly affected by minor physical illnesses, did not adjust well in school, were considerably upset at the age of puberty, did not react well in competition, did not enjoy sports, were emotionally dependent, and were always inclined to take themselves too seriously. The training which these individuals received as children materially enhanced or decreased their tendency to have serious and handicapping neurotic manifestations. Under conditions of strain they react with a neurotic pattern which was usually developed in childhood. Military experience has helped some of these people by hardening them up, giving them something to be proud of, and strengthening their ego. Others have been made much worse by the same experience, some of whom will become sorry for themselves and feel that they are entitled to special consideration which they will not receive from a war weary world.

6. *The Acute Psychoneuroses.* A considerable number of men who return from the War will be suffering from this type of difficulty. In general their neuroses will not differ essentially from those seen in civilian life, with this exception: they will be largely colored by military experience and complicated by difficulties in readjusting to civilian life. Most of the men who have suffered acute neuroses while in the Army will have received sufficient treatment to get them back to duty or to return home. Many of them will not have any real understanding of the nature of their illness, nor know how to handle themselves to prevent future breakdowns. A considerable number of them will have acquired misinformation in regard to the nature of their illness, and some will be so ashamed that they will fabricate explanations which they themselves quickly come to believe—all of which interferes with insight, the integration of personality, and recovery. A great number of the psychoneurotic cases will clear up spontaneously with the termination of the War or military service, only to reappear later in civilian life. With the outbreak of World War II a number of older men who had suffered neuroses in World War I, having remained fairly well in the interim, under the impact of war conditions, reestablished their former war neuroses. Their neurosis could be treated successfully only by going into their former illness. This gives some idea of how lasting psychological trauma can be, and indicates the urgent need of clearing up these psychiatric difficulties now in the young men returning home.

I have stated that the psychiatric clinical pictures encountered in these men are essentially the same as those encountered in civil life. There are two exceptions to this rule. As a result of fatigue, prolonged fear, and the need to be ever alert, many men become chronically overmobilized, show increased psycho-motor activity, have "startle reactions," and evidence transient vago-sympathetic symptoms. This condition gradually clears up with rest, reassurance, recreation, gradual adjustment to normal life, and absorbing new interests, but may persist for a number of months after the individual returns to civilian life. Another reaction which occurs after long and disillusioning military experience is a state of chronic fatigue and persistent loss of interest. To these men civil life seems an anti-climax after their more exciting experiences. They have lost their normal ambition and perspective and have a sense that nothing is worth the effort. If these men are too strongly urged to resume civilian life at once, they may develop neurotic symptoms which they ascribe to the War.

7. *The social problems of the returning soldier.* These will be numerous but chief among them are those relating to family, marriage and work. The most important problem will have to do with marital adjustments. The nature of this problem is twofold and self-evident. Many young people who married during the War have been separated for long periods of time, the courtship basis of marriage has worn off,

they have not developed mutual interests, they do not understand one another, and the young man returns home to a heavy burden of responsibility which, frequently, he does not know how to meet. Many couples are held together only by the sex instinct and a sense of duty, either or both of which may disappear. It is frequently hard for them to understand that they have to start their marriage all over, build up an enduring love relationship and develop mutual interests. The second group are those who marry hurriedly as soon as they return home, or shortly after meeting one another, or on the mistaken basis that each has remained unchanged throughout the War. These war marriages and hurried post-war marriages are giving rise to problems of psychiatric importance.

In all of this nothing has been said of the wounded soldier and his emotional problems since it has been found in past wars that wounded and disabled men who have a definite, known, and understood handicap to adjust to, do so remarkably well—indicating that it is the unknown and not understood factors of life which continue to harass and handicap human beings. This fact points the way to the treatment of these psychiatric problems; namely, by giving the individual an understanding of his condition and teaching him a satisfactory, workable technic of living. It should be stated that if a neurotic individual is wounded it does not cure his neurotic patterns, but in general, physical injury does not aggravate neurotic temperament.

Having outlined the nature of the ex-service man's psychiatric problems, the next step is to describe therapeutic procedures for meeting these difficulties. If some of this seems vague I shall beg your indulgence and try to make it as concrete as possible. Two things are indicated: better psychiatric facilities in the community, and more training in psychotherapy for the general practitioner.

The War has dramatically revealed the number of male patients who need psychiatric assistance. They all cannot and should not be cared for by state and federal institutions. There are approximately 550,000 beds in all of the state, federal, county, city and private mental hospitals, yet a million men were found by the Selective Service to have psychiatric difficulties and I have suggseted that they discovered only half of these cases; and doubtless quite a few ex-service women will evidence psychiatric problems. So it becomes evident that the medical problem of caring for these patients is one of great magnitude, and it can only be met if proper facilities are provided.

I suggest that general hospitals should immediately create facilities to care for psychiatric patients, both as in-patients and out-patients. Hospital managers have been averse to doing this largely due to ignorance and prejudices. It has been repeatedly proven that psychiatric wards and clinics need not be a disturbing factor in general hospitals and if so, the general hospitals should learn to cope with such situations. Individual psychiatric patients are now a disturbing element in a general hospital because facilities have not been provided to care for them and in many communities no competent man is available to care for such patients. This brings up the point that medical men should encourage psychiatrists to settle in their communities after the War, cooperate with them and help to provide facilities for their work. Many competent young psychiatrists will be looking for a place to settle after this War; this will be a good chance to persuade an able man to come to your community. He will save the general practitioner many a headache and make his work much more interesting.

Next, many general practitioners need more training in brief, rational, effective psychotherapy. The intelligent, experienced doctor has done surprisingly well using a common sense, hit or miss form of psychotherapy, but a short graduate course in scientific psychotherapy would pay enormous dividends as applied both to the treatment of the ex-servicemen and to general practice. Such graduate courses in psychotherapy should now be established in medical centers and also should be offered as a part of the general refresher courses which are given by the American College of Physicians. In speaking of such courses, I am specifically referring to what has been called the reeducational approach to treating psychiatric problems; a technic which can be understood easily, has a broad field of applicability, and is based on all known psychopathology.

Now to be more specific—the first job before physicians is to render assistance to those rejected selectees who have been upset by this experience. In many instances their confidence in themselves must be restored and the doctor must comfortably rationalize the cause of their rejection. To do this, first discuss the questions which were asked them by the psychiatrists on the Induction Line and try to get their answers to these. Then go into the patients' life histories in some detail. The purpose of doing

this is to give them a chance to air their grievances and enable the doctor to form some idea himself as to why they were rejected. Try to help them understand the nature of their difficulty in simple constructive terms, avoiding technical diagnostic phrases. Explain that they were not rejected, they were just not accepted for military duty; that this was for their own protection, and because they could be more useful to the nation in other lines of endeavor. Reassure them about their own essential fitness for civilian life, pointing out that many of the qualities which make for a successful civilian do not necessarily make for a good soldier; for example, extreme sensitiveness. Try to dispel any prejudice they may have about nervous difficulties in general, make them feel that these are nothing to be ashamed of. If time and opportunity permit put them through a short course of applied personal mental hygiene reeducation, pointing out that they will look back on this entire experience as an opportunity in understanding themselves, human nature and life in general, that they have acquired useful knowledge which will enrich their lives.

Many early and curable psychotic cases could be handled locally if proper facilities were available. If these are not at hand one must use state and federal hospitals in caring for psychotic ex-servicemen. Physicians are familiar with the legal procedures for placing such patients under state care. When the physician wishes to provide federal care for ex-servicemen with psychotic difficulties, he should apply directly to the nearest Veterans' Administration Facility. The local Red Cross and the American Legion can be of assistance in furthering this process, and it is wise to ask for such help since the Veterans' Administration may have a waiting list. If the man has been in the Navy, treatment can be speedily provided for him by communicating with the Commanding Officer of the nearest naval hospital. If these psychotic patients are placed under either state or federal care some of them will be entirely cured, many will be helped. It is important that the doctor maintain an optimistic attitude in regard to recovery both in speaking to the patient and to his family. Great progress has been made in the successful therapy of psychotic patients in recent years. Insulin and electroshock therapy, psychotherapy, social therapy and occupational therapy work miracles in many cases. These patients and their families must not be allowed to acquire a hopeless attitude. An expectancy of recovery is a step towards its occurrence. The family physician should keep in touch with these patients, their families, and their doctors while they are in a hospital. Try to find out what is being done for them, and encourage their doctors to use active and intensive therapy. It also helps to let the hospital physicians know that the family physician stands ready to help readjust the patient when he returns home.

One thing more should be stated at this time. If the family physician wishes information as to the patient's medical history while in the service he can get it by applying directly to the commanding officer of the hospital from which the patient was discharged, or by applying to the Surgeon General's Office of the Army or Navy; however the quickest procedure will be to apply directly to the commanding officer of the hospital. The request for information must be accompanied by written permission from the patient or from a responsible relative, authorizing that such information be sent you. Any information so obtained should be treated as a confidential professional communication, and not shared with the patient or family. The United States will probably have an Army for a long time. We must support the doctors in the Army Medical Corps as we do our civilian confreres, and for the same reason, for the protection of the patient.

The management of the psychopathic personalities is the hardest and most unsatisfactory problem; yet these patients must not be neglected for they are always in our midst as a source of discord and personal unhappiness. They can best be helped by making friends with them, encouraging them to unburden themselves of their grievances, by discussing their troubles and trying to simplify their lives. One should attempt to get these people to settle down to a quiet, routine existence, a planned way of life which will keep them away from harmful and disintegrating influences. They do best on a farm as far as possible from a large city, leading a semi-solitary existence, occupied in some more or less satisfactory undertaking. If the doctor can keep these individuals from making undue trouble for themselves and others much will have been accomplished.

The medical management of the psychoneurotic personality and the treatment of the acute phychoneuroses is fundamentally the same. It is frequently a matter of treating both them and their families since the latter may play a part in the patient's illness. It is important that these patients not be allowed to blame the War entirely for their condi-

tion for if they do so it will deprive them of the insight which they need. Every effort must be made to prevent their becoming confirmed neurotics; therefore, they should be treated intensively and at as early a date as possible. They are young, life is ahead of them, and much can be done for them.

The greatest hazard that exists in treating ex-servicemen who are psychoneurotic is that they are eligible for federal pensions. Once these men have applied for a pension or have secured one, it becomes practically impossible to cure them. Few compensation neuroses recover as long as the compensation continues in effect. It is unfortunate that recent federal legislation makes these patients eligible for pensions since this very fact will make many confirmed chronic neurotics of individuals who would otherwise recover. Such federal provision was made without consultation with medical authorities familiar with this problem. Following World War I the German government handled this situation wisely inasmuch as they provided only temporary treatment and compensation, in no case for a longer period than one year, in caring for their psychoneurotic soldiers. Our government should follow a similar course in dealing with the psychoneurotic problems of World War II. This is a matter of such great importance that state and national medical societies should make a determined effort to combat this dangerous situation, to have new legislation passed, in an effort to save hundreds of thousands of young men who are otherwise doomed to a miserable and useless life by a group of medically ignorant politicians.

In spite of the fact that existing federal legislation will make it difficult for the doctor to help many of these patients, the family doctor may be able in many cases, because of his close association with the families and patient, to save some of these patients from this hazard. In an effort to do this he should urge these men *not* to apply for pensions, pointing out the nature of the risk and showing them that by accepting pensions they are selling their birthright of happiness and usefulness, dooming themselves to life long discomfort, all for a mere pittance.

In treating the psychoneuroses it is wise to avoid drugs as much as possible, particularly sedatives. Too many neurotics become dependent on sedatives whose chief value is that they keep the patient from bothering the doctor. It may be accepted as an axiom that in the long run a neurosis is not helped but is made worse by the use of sedatives. Likewise one should avoid the error of rationalizing the patient's symptoms on the basis of a physical disorder, since these individuals are all too ready to accept such explanations along with special diets, drugs and operations, although in their heart many of them know better and would accept a rational, constructive explanation with gratitude. Instead one must listen to their stories in detail and ascertain the real cause of their difficulties, both constitutional and psychogenic. It is important to secure a good emotional transference and when necessary to combat psychological resistance skilfully. The nature of their illness must be explained to them, they must be taught technics of adjusting, must be reassured, and good suggestion must be employed skilfully and unstintingly. A man who has an acute psychoneurosis is like a person who thought he knew how to sail a boat and suddenly finds himself in the water, having capsized the boat. He is frightened, ashamed, angry and confused. He needs to be reassured by someone with a sense of humor who can point out how often this happens to the best of sailors. After such an unexpected accident it is frequently hard to crawl out of the sea into a rescuing boat, and the individual in such a predicament frequently needs to be given an added impetus at the right moment to help him over the hard edge. That is where the doctor comes in—he pulls the patient out of his difficulty. Then the individual needs to be shown where he made his mistake and how he can avoid it in the future. It is a good plan to keep in touch with these patients as they get better, encourage them to return until their reeducation is complete and they are comfortably adjusted, and then leave them alone. The doctor will have to encourage these people to go back to work for some of them have lost confidence. Many of them will need to be taught the value of a balanced life made up of work, rest, exercise and play. Similarly they must be taught to seek new interests in life. Each person has to live through many frustrations in a lifetime, and must be able to find ways to sublimate these frustrations. The physician attempts to measure the amount of strain that the individual can withstand and yet maintain his efficiency. Having done this he encourages the patient to live within the scope of his abilities and temperament .

The physician who is secondarily interested in the social problems of the ex-serviceman, and then only because frequently he is looked to for such advice, realizes that if these social problems are not more or

less satisfactorily settled they may give rise to illness. In the next five years many a doctor will be consulted about marital maladjustments which have occurerd as a result of war marriages. Most of these people should be held together, the doctor explaining that in general marriage is what one makes of it. Many young men can be helped by having the philosophy and technics of marriage explained to them. In general it might be said that a man's life is supported by three legs of a tripod—a home, work and a hobby. Each of these is a three way brace against the strain of living. Doctors should encourage the ex-soldier to have and retain all three.

The best advice that the physician can give an exserviceman about returning to work is that after a short period of rest, recreation and familiarizing himself with changes in society, he take off his coat, roll up his sleeves and go to work. Help him to find a purpose in life, suggest that he determine what he wishes to accomplish, help him to work out a five year plan as to what he can reasonably expect to accomplish in the next five years and to then get busy doing it. Help him to understand that this is his world, that he must try to be a part of it. Help him to realize the War is over, is to be put behind him, that there is no longer any one to give orders, so he must give the orders himself; that today is the only reality—and it is one to which he can adjust.

In conclusion it can be said that the rehabilitation of the psychologically war traumatized soldier is inevitably a part of the general practitioner's job. He must accept the challenge, provide additional community psychiatric facilities to care for such patients, secure the additional training is psychotherapy which he needs, and enjoy being a part of a new and interesting phase of medicine.

Our type of civilization has been fertile soil for the encouragement of psychiatric problems. The War has shown this weakness and in an effort to overcome it physicians should insist on more intensive health education for the children of the coming generation. This should be along the lines of both physical fitness and mental hygiene training in our schools. It is our duty to try to fortify coming generations from as many psychiatric risks as possible. At best we can only do a patch-up job with the psychiatric problems of the returning soldiers, but it is necessary and one well worth doing.

# Campaign Started for Society's New Home

With an impetus of about $6,000 in pledges and gifts from the Council and the Trustees of the Building Fund, the campaign for $50,000 to defray the cost of a new home for the Society is off to a good start. Every member has received a copy of the prospectus describing the need and the plan for the campaign and with each prospectus was enclosed a sketch of the proposed new home. Of fundamental importance is the fact that large quarters are needed in which to house the executive offices of the Society. After 150 years of service to the citizens and to the medical profession of the State, it is fitting that the dignity as well as the efficiency of the Society should be maintained in surroundings proportionate to its prestige. The Society has approved the project of having a building of its own in New Haven and has appointed a Board of Trustees of the Building Fund to proceed toward that objective.

It is contemplated that to meet the needs of the Society the new home should provide space for the Executive Offices, the office of The Journal, the Society's files and rapidly expanding working library, the office of the Treasurer and his accounting procedures, a safe for the protection of documents and records, an office for the Woman's Auxiliary and one for the Tumor Committee. In addition there should be Council and committee conference rooms and, if possible, a small auditorium to accommodate the House of Delegates. Due to the exigencies of war the date of construction cannot be set, in fact, it may seem wiser to purchase a suitable building already in existence, should such be found.

The sum of $50,000 would seem to represent an investment, the manitenance of which would be within the means of the annual income of the Society, while at the same time it should meet the needs of the Society. Contributions to the Fund will be made to the Board of Trustees and they may be paid in three annual installments. Our members absent in military service will not be solicited and it is hoped that by the time they return to us the Fund will have been raised and we can, in a sense, present them with a home for their Society.

Pledge cards were enclosed with each prospectus mailed to every member of the Society with suggested amounts of annual contributions printed thereon and space left for the donor to write in another sum if none of the suggested amounts is what he wishes to contribute. There is also a suggested time for payments with the first payment now or in April 1945. The Medical Society of New Jersey has recently purchased a home for itself. Other State Societies have found it advantageous to make a similar investment. This seems to the Council an opportune time for our Society to acqaire its own home.

*Fill our your pledge card and return it NOW!*

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*



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# EDITORIAL

## A New Year

With this first issue in 1945, the JOURNAL extends its New Year Greeting. Never before have men of good will looked forward with more eager anticipation or fervent hope. The events that will come in the near future seem inevitably to be those which will mark one of the turning points in civilization. If it is true, as Oliver Wendell Holmes said, that "The state of Medicine is one index of the civilization of an age and country" then the responsibility of Medicine in these times becomes very great. There is ample proof that our Society is aware of this. Everyone who has read the recently published letters from our colleagues in foreign fields must have been impressed by the expressions of deep interest in the medical-social problems that face us now and in the future. The same concern is witnessed in the deliberations of representatives of the Society as published in reports in this JOURNAL. As a Society and as individuals we are aware of the magnitude and complexity of the problems which Medicine faces and we shall meet them with high success only through that wisdom whose chief inspiration comes from a deep devotion to the ideals for which the Society was founded. It is obvious that the strength upon which we must rely for the best solution of the problems of the future rests fundamentally in the members of the Society and not in its officers. To each of us, therefore, the opportunities to advance the interests of Medicine and the public welfare must not only be taken when they are realized, they must be sought and found.

The planning of a permanent home for the Society presents one of the great opportunities. The benefits which will come from this project are many and have been often set forth. The advantages which will come to the individual physician have not been particularly emphasized but they are none the less clear. It is safe to say that there are very few physicians in the state who have not at some time had contact with the Society's central office since it has

been established and that contact has always been of helpful assistance. This New Year offers many challenges to Connecticut physicians and none promises more good than the completion of the Building Fund and the announcement of that fact to our friends who are serving their country.

Speaking before the Centennial celebration of the Connecticut State Medical Society, Dr. Francis Bacon of New Haven painted a picture of social conditions in Connecticut at the time of the founding of the Society. Although somewhat Utopian in its delineation, history tells us that it was largely true. At any rate we can look with profit into this record of our past for a message of hope for the coming years. He said, "But the sun rose nowhere upon a people better fed, clad and lodged, more free from the nuisances of pauperism or the idle rich, more enterprising and industrious, more law abiding and tenacious of right, nor more eager for the education which made and kept them so, than the citizens of this little commonwealth."

## Intern Training

Two major problems which face Medicine in the post war period are concerned with post graduate medical training for the returning physician veterans and the training of interns. Among the former there will be many who desire to complete hospital training particularly in the specialties and with others the main interest will center in refresher courses in fields which of necessity have been neglected during the war. As far as these two groups are concerned it is obvious that the medical schools and the associated teaching hospitals can offer but relatively limited aid and that for the most part the burden of any definite program must rest upon the medical profession itself. Hospital training as we now know it must be carefully surveyed with a view to greatly increasing its usefulness, and those who are in positions of its responsibility must become aware of their obligations and opportunities.

In our own State, hospitals have for many years offered intern training but for some time previous to the war it was quite evident that for many hospitals there existed a real shortage of well qualified applicants for such training. That this shortage has not become one of major significance during the war is largely due to the excellent functioning of the State Office of Procurement and Assignment.

It seems unquestionable that if in the future we are to maintain an adequate and useful intern training program in Connecticut the effort must be a carefully coordinated one and one in which this type of post graduate training will be attractive to graduating students of good medical schools. The suggestion has been made that a permanent committee consisting of representatives of hospital administration and members of the profession could serve as a useful body to consider these problems and other pertinent hospital and professional relationships.

Dr. E. M. MacEwen, president of the Association of American Medical Colleges, speaking of the internship, said recently, "Few, if any, of us are satisfied with the educational program offered graduates in many fully approved hospitals. The internship must be a part of the physician's preliminary education, not primarily a hospital service. Educational requirements should be added to the present service standards required for approval. So far as I know, no responsible group has ever formulated such a program. Even our best hospitals are so definitely centered on the training of specialists, that the intern year differs little from the senior year except for freedom from formal class work. We hear on all sides the demand for more general practitioners—if this demand is to be satisfied, we must develop a number of two year rotating internships with a teaching and service program keyed to the needs of this type of practice." It is certain that most hospitals will welcome a carefully considered program for future intern training and it is hoped that in our own State that the time will not be long before something constructive can be offered to those who are now responsible for this important aspect of medical education.

## A Prepayment Medical Service for Connecticut

The House of Delegates, at its meeting on December 7, in accepting the recommendations of the Committee on Prepaid Medical Service placed in motion the final mechanism of a program which should result before many weeks in a prepayment medical service plan for Connecticut. While the technical operations of the plan will be carried on by the Connecticut Hospital Service, the plan itself will be administered under a new corporation, to be known as the Connecticut Medical Service. It is tentatively planned that this new corporation will have a directorate of eleven members; four to represent the Connecticut Hospital Service, four to represent the Connecticut Medical Service, and

three who shall represent the public and subscribers. The contract to be written will be on the cash indemnity basis and will cover surgery and obstetrics done in the hospital. It is hoped by many who are interested in the plan that professional service to medical cases can be added later to the coverage, but for the present this does not seem feasible. The members of our Society should be aware that in this cash indemnity plan there is no attempt at regulation of the professional fee, but it is obvious, if misunderstandings are to be avoided, that the patient should have a full understanding of the charge for professional service. This means that a clear understanding of the objectives of the plan and a close cooperative effort must be shared by its administrators and the members of the Society. It is thought that the plan should proceed somewhat slowly at first until familiarity with the machinery of operation is gained by its administrators. As developments go forward, our readers will be kept informed through the JOURNAL. At the present time the efforts of the committee are to be greatly commended for having brought to a stage of real fruition a project which has so long occupied the thought of our members.

## The Junior Membership

The change in our by-laws which will permit the addition of junior members is a unique step in our annals, and, as far as we are aware, one never before projected by any similar organization. Its primary object is to acquaint Connecticut students in medicine with medical practice in our State by welcoming them to our meetings, and through the medium of the JOURNAL. It is natural that many of these men will subsequently wish to practice in Connecticut: they are the physicians of our tomorrow and it is certain that our members will feel that we, as well as they, will gain by this new plan. The unanimous vote of the House of Delegates favoring this worthy and interesting project is another expression of the forward thinking of those who govern our affairs.

## Catholic Hospital Association Opposes Medical Practice by Hospitals

In view of the present interest in Connecticut of hospital relationships to medical service the following resolution recently adopted by the Catholic Hospital Association is of interest. The resolution follows:

"Be It Resolved, that this Association accept the viewpoint of some of the physician members of the staffs giving general services at the hospitals, that is, of the pathologists, the radiologist, the physician anesthetists, and the physiotherapists, in their contention that through certain forms of contract with these physicians, the hospital actually enters into a contract to practice medicine. The member institutions of this Association are, therefore, strongly encouraged to take such steps as could eliminate all misunderstanding concerning this point by attempting to modify existing contracts if they contain features exposing the hospital to the charge of attempting to practice medicine. On the other hand, this Association is no less strongly convinced of the fact that difficulties on the matter just indicated are traceable not only to hospitals but often to the physicians, who, for one reason or another, have entered into forms of agreements with hospitals which have exposed both themselves and the hospital to the dangers of misunderstanding. The Association is convinced that its member institutions are most anxious to enter into relationships with physicians, contractual or otherwise, which imply ethically sound relationships and it requests the staff physicians of the Catholic hospitals to devise such procedures as may be professionally defensible while the Association itself will seek to place before its members, those considerations which are in accord with sound and basic principles of ethical hospital administration."

An address by Goronwy O. Brown, M.D., before the Association at its annual convention pointed to the need for revising fiscal arrangements with radiologists and other specialists in hospitals where these doctors have been employed on salaries. Said Dr. Brown, "There is evidence that the hospitals in the not distant future will have to review their relationships with those members of the medical profession who now customarily are employed on a salary basis for the operation of such facilities as the departments of radiology, physio-therapy, and the clinical and pathological laboratories. There is a distinct feeling that certain prerogatives of medical practice have been withdrawn from the physicians engaged in these specialties and assumed by the hospitals—that the hospitals are, in a sense, engaged in the practice of medicine. Moves to correct the present conditions may be expected and will constitute one of the problems requiring solution in the post war era."

## Conference On School Health Education

In this issue we present two papers and a summary from the second wartime conference on School Health Education held under the auspices of the State Department of Education and Health and the Connecticut Tuberculosis Association at New Haven, Oct. 6, 1944. These reports from this conference are of importance to the physicians of our state not alone because they should be informed on these problems but particularly because they are so essential in the program. Dr. Derryberry points out that the interests and skills involved include not only the teachers, the school physicians, and the nurses but the family physicians and in many instances specialists. Because of such a diversity there are many opportunities for slips and omissions and even the "alibi game of buck-passing." Of importance is a redefinition of goals in the health instruction phase of the program and the development of more precise tools of evaluation. Dr. Powers speaks of the influence of emotional factors on the health of children now emphasized by the impact of war on the lives of children and adults alike. Taken in its entirety the program for School Health Education presents vast proportions but the magnitude of its importance is unquestioned when we consider the contribution which it can make to the future of our civilization.

## Dr. Leak Accepts Appointment

Roy L. Leak, ex-president of the Connecticut State Medical Society and formerly superintendent of Connecticut State Hospital at Middletown, has been called from retirement in West Hartford temporarily to assume the superintendency of the Norwich State Hospital. Dr. Leak succeeds the late Dr. William A. Bryan. The acting superintendent at Norwich has a host of friends in Connecticut who wish him all success at this new post.

## Lieut. Col. James C. Fox Awarded Bronze Star Medal

Lieut. Col. James C. Fox, who directed the organization of the Yale Medical Unit (39th General Hospital) and served as its chief medical officer during two years of operation in the South Pacific theater, has been returned to this country for a brief leave and subsequent reassignment to important duties by the War Department. It is also announced that Lieut. Col. Fox has been awarded the Bronze Star Medal, with the following citation: "For performance of meritorious service in connection with military operations in the South Pacific from November 1942 to October 1943, as chief of the Medical Service of a general hospital. Colonel Fox organized and continuously supervised the professional service that provided superior definitive hospital care for more than 15,000 medical patients over a period of 20 months." Prior to receiving his commission Lieut. Col. Fox was associate professor of medicine and practiced neurology and neuropsychiatry at the New Haven Hospital.

## A. M. A. to Meet in Philadelphia

Because of conditions brought about by the war the necessary facilities will not be available in New York City in June for the 1945 annual session of the American Medical Association. Instead, arrangements have been made to meet in Philadelphia, June 18 to 22, one week later than the date originally scheduled for New York City.

## 1944 Initiates, American College of Surgeons

| | |
|---|---|
| John F. Brosnan | New London |
| William B. Koufman | New Haven |
| Ashley W. Oughterson | New Haven |
| Frank Turchik | Bridgeport |
| Arthur C. Unsworth | Hartford |
| Charles A. Whitty | Hartford |

This States the Case for Professional




Season's Greetings
to our many Connecticut doctor and hospital friends

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## SPECIAL MEETING OF THE HOUSE OF DELEGATES

The usual Special Meeting of the House of Delegates was held in New Haven on December 7 and the following actions were taken.

## 1945 BUDGET

The House adopted the budget for 1945 as recommended by the Council and continued the annual dues at $20.00.

### Amendment to the By-Laws

The By-Laws of the Society were amended to provide for student memberships.

### Membership

Chapter II of the By-Laws of The Connecticut State Medical Society is amended by the addition of a new Section 3. The present Section 3 becomes Section 4 and the present Section 4 becomes Section 5.

SECTION 3. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 478f of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as internes or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of the Society.

Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Student Members will enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office.

When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

### The Inclusion of Professional Fees In Payments Made by Hospital Service Plans

The recommendation made by the special committee to study the inclusion of professional fees in payments made by hospital service plans that was tabled by the House of Delegates at its Annual Meeting on May 2, 1944, was taken from the table on recommendation of the Council and the House voted to adopt the recommendation made by the special committee in its report of last May **opposing the inclusion of professional fees as a part of any hospital service plan.**

### Prepaid Medical Service

The Committee on Prepaid Medical Service presented an illuminating report which was adopted and the committee was authorized to proceed according to the recommendations contained in the report.

THE REPORT

The Committee on Prepaid Medical Care has had several meetings since spring. At one of the meetings the Massachusetts Prepaid Medical Plan—a service type plan—was explained by its director, and a discussion of the problems in Massachusetts followed.

Your committee began discussions last spring with a committee appointed by Connecticut Hospital Service Incorporated to study the prepaid medical plan relative to cooperating in offering to the people of Connecticut a prepaid medical plan on a cash indemnity basis. The committee from the hospital plan wished to offer much greater coverage by sponsoring a service type contract. After a great deal of discussion and correspondence between the Chairmen of the two committees your committee voted unanimously last August to express to Connecticut Hospital Service Incorporated that it would support only the cash indemnity type plan, that a plan must be offered to the people of Connecticut without undue delay, and that if Connecticut Hospital Service was not interested in cooperating with the Connecticut State Medical Society in forming such a plan, the Society would seek the support of other agencies. The committee from Connecticut Hospital Service Incorporated after this ultimatum had been recieved decided to accept the cash indemnity plan and recommend it to their executive committee.

After some delay a meeting of the executive committee, and later of the Board of Directors of Connecticut Hospital Service Incorporated was held on November 15 to consider the plan. Doctors Jarvis, Miller, Barker, and Root were invited to these meetings to express their views. After thorough discussion the executive committee voted to recommend our plan to the Board of Directors. Here, due to lack of knowledge of the plan, of the legal angle of starting a new plan, of the financial angle, and of the Hospital Plan's responsibility in the medical plan, certain objections were raised. It was voted, however, that the Hospital Plan committee work with the Connecticut State Medical Society's committee to develop a prepaid medical plan on the cash indemnity basis to be presented for approval when completed.

Dr. Barker and Mr. Hoit of Connecticut Hospital Service Incorporated have already done a good deal of ground work on the plan, and will, with legal assistance, draw up a plan on the following lines.

A new corporation be formed with a Board of Directors of perhaps eleven members, four to represent Connecticut Hospital Service, four to represent the Connecticut State Medical Society, and three others to be elected by those eight who shall represent the public and subscribers. This new corporation to be called Connecticut Medical Service.

Connecticut Hospital Service to provide a sum not to exceed $5,000 to which the Connecticut State Medical Society will add an equal sum not to exceed $5,000, to provide a fund to start the corporation in operation.

The technical operation of Connecticut Medical Service shall be carried on by Connecticut Hospital Service but all funds of the two corporations, obligations and assets shall remain separate so that the indemnities paid by Connecticut Medical Service will come from premiums collected by that corporation and will in no wise jeopardize the accumulated surplus or income of Connecticut Hospital Service. Agreement shall be made by Connecticut Medical Service to pay a fixed proportion of its gross income to Connecticut Hospital Service for administrative, sales and promotional expenses. This fee might be ten per cent of premium income, for example, and subject to adjustment from time to time.

It is suggested that the contract to be written be on the cash indemnity basis and follow in a general way a cash indemnity contract that has already been worked out by the State Medical Society in cooperation with the actuaries and underwriters of a commercial insurance company. It would be advisable that at first the contract to be written should not be as liberal in its provisions as the contract referred to. And as experience accumulated it would be hoped that the contract might be liberalized but at first to start it well within the zone of underwriting safety.

Your committee feels that Connecticut Hospital Service is the logical organization to cooperate with the Medical Society in offering this plan for many reasons, and has not contacted any of the insurance companies pending the outcome of the plan under discussion.

## The Status of Nurse Anesthetists

The Committee on Public Policy and Legislation at the request of the Council has inquired into the legal status of nurse anesthetists and presented a report which was adopted by the House.

THE REPORT

On October 12, 1944 the Committee was informed that the Council of the State Medical Society, at its regular monthly meeting on October 10, 1944 voted to:

"Request the Society's Committee on Public Policy and Legislation to seek the cooperation of representatives from the Connecticut Hospital Association to inquire into the legal status of Regis-

tered Nurses giving intravenous medication, including anesthesia, with the view of legalizing such procedure in acceptable hospitals by the passage of appropriate legislation and report its recomendations to the House of Delegates of the Society in December 1944."

Information was sought from the Bureau of Legal Medicine and Legislation of the A. M. A. In a few States legalizing acts have been passed so that a Registered Nurse may administer anesthetics under the direction and in the immediate presence of a licensed physician or surgeon, provided such nurse has taken a prescribed course of anestehsia at a hospital in good standing. In other States where such legislation has not been passed, several court actions testing the status of the surgeon or nurse have been tried. Each decision has favored the surgeon when he delegated technical procedures, such as the administration of intravenous anesthesia to a properly trained nurse under proper circumstances, and other court actions have favored the nurse under similar circumstances.

Several conferences have been held with Mr. O. H. Bartine, Superintendent of Bridgeport Hospital, and Chairman of the Council on Government Relations, (the Legislative Committee) of the Connecticut Hospital Association. He has been unable to call together the entire committee, but he submitted the following memorandum on November 16, 1944:

"I have just had a talk with Judge Arnon D. Thomas, Attorney for the Council on Government Relations of the Connecticut Hospital Association, and he advises relative to the legal status of registered nurses giving intravenous medication, etc., that it is unwise at the present time to prepare any legislation or to bring the matter up before any association for official action."

This information was distributed to the Members of the Legislative Committee by mail and the committee is in agreement on the following conclusions:

(1) The Connecticut Hospital Association Legislative Committee does not desire to propose legislation to legalize the administration of intravenous medication, including anesthesia, by Registered Nurses.

(2) We may apparently safely proceed as physicians and surgeons in our present hospital practice of delegating technical work to trained personnel under proper circumstances.

Therefore, the committee recommends that no legislation for this special purpose be proposed at this time.

## State Group Professional Liability Insurance

The special committee, under the chairmanship of Louis F. Wheatley of New Haven, presented a report on the consolidation of the several professional liability insurance groups within the state and the House adopted the committee's recommendation that these groups be consolidated in accordance with the plan proposed by the Aetna Casualty and Surety Company. The details of the plan will be published later.

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### NEW ARTIFICIAL EYE

The American Optical Company announces it is now engaged in the manufacture of a new artificial eye made entirely of plastic materials.

AO's new artificial eye is unique for two reasons. First, it is made entirely of non irritating plastic materials and second, its iris is realistically implanted by a photographic reproduction. Both of these improvements are new in respect to commercially made artificial eyes, and enable a fitter to provide for his patient an eye that is durable, correctly fitted, and identical in color to the good eye.

The plastic composition of the new eye offers protection against its chipping, shattering, or exploding when subjected to sudden temperature changes. Accordingly, the new eye will last for years. A patient requiring an artificial eye may choose between a stock eye or one made to order. Permanent molds for different eye sizes will provide the stock eyes.

Up to this time the United States has had to rely almost entirely upon foreign sources for its glass eyes. AO's new type eye has not only outmoded the old, but has freed the United States from foreign dominance and dependence in this field.

However, because production plans cannot be in full operation for some months, and because military requirements are expected to be heavy, the supply of AO plastic eyes for civilians will be limited for some time to come. Further announcements will be made as the new AO plastic eye division expands its production.

This States the Case for Professional




Season's Greetings
to our many Connecticut doctor and hospital friends

# 1944 SECRETARY-EDITORS CONFERENCE AT CHICAGO

STATE MEDICAL SOCIETY secretaries and editors of the various State Society journals held their annual conference in Chicago on November 17 and 18, 1944, as guests of the American Medical Association. The conference was greeted by James R. Bloss, chairman of the Board of Trustees of the A. M. A., and by the president, Herman L. Kretschmer, and the president-elect, Roger I. Lee.

### NEW BUREAU OF INFORMATION

At the first session Lt. Col. Harold C. Lueth, Army Medical Corps, Liaison Officer, described the formation and function of the new Bureau of Information. This is a recent development in post war planning that has been undertaken jointly by the Office of the Surgeon General of the Army, the Procurement and Assignment Service, the American Medical Association, and the State Medical Societies in order to provide information of all kinds to medical officers discharged from military service. The service will be divided into two parts: (1) information concerning educational possibilities and opportunities; (2) information concerning localities where discharged medical officers may contemplate establishing themselves in practice. The central office is to be located at the A. M. A. building in Chicago under the direction of Lt. Col. Lueth. Statistical information will be collected through the use of a county information sheet, the data being supplied by the state offices of the Procurement and Assignment Service and the State Medical Societies, and will be machine tabulated for ready interpretation and distribution. Information Service will not be an employment or placement agency. Inquiries relative to the characteristics of localities in which physicians contemplate settlement will be forwarded to the Service in Chicago by individual officers and the information concerning the particular localities will be provided by Colonel Lueth's office. By making contact with the State Medical Societies and with the state offices of Procurement and Assignment, it is believed that a procedure will be effected that may lead to the successful and satisfactory relocation of the physicians discharged from the Forces.

### COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

Chairman John H. Fitzgibbon discussed the accomplishments of this comparatively new council of the A. M. A. and the operation of its Washington office under Joseph A. Lawrence, formerly an official of the Medical Society of the State of New York. Regional conferences are being held with the state medical societies as part of a plan to inform the latter more intimately of the program of this Council.

### THE EMIC PROGRAM

The afternoon session opened with a frank discussion of the Emergency Maternal and Infant Care program led by E. D. Plass of the Iowa State University College of Medicine and Thurman B. Rice, state health officer of Indiana. Dr. Plass indicated the federal program at the outset by informing his audience that it had scrapped the standards previously attained by the medical profession in permitting cultists to care for the wives and children of men in the armed forces, and by permitting no other arrangement between patient and physician under the plan except the one prescribed, thus forcing both parties to take it or leave it. In order to carry out this program the Children's Bureau has dropped its previous and valuable investigative work on such problems as eclampsia. The so-called emergency justifying the EMIC program has not been proven. Only about 10 per cent of our service men's families come under this plan, the remainder of the wives not being eligible. Dr. Plass accused the Children's Bureau of making "wise concessions to maintain its machinations." The ultimate goal of the EMIC program is recognized as a federal health program for the self supporting as well as for the needy. And to add to all this, the program has created within the medical profession a split personality, offering the attraction of the almighty dollar to the physician whose fees have been lower than the schedule adopted, and encouraging unnecessary and prolonged care where such was not the practice heretofore. Resolutions decrying the present program are of no value now. The local representatives of Congress must be reached personally and appealed to if any relief is to be obtained from the present program.

### THE BEAR BY THE TAIL

Dr. Rice was more charitable than Dr. Plass in that he expressed the belief that the EMIC program

was not set up originally to control the entire health program, but has grown so fast and to such huge proportions that the Bureau now has the bear by the tail and once committed must stick by its guns. Dr. Rice called attention to the wording of the Act creating EMIC—"under allotments by the Secretary of Labor and plans developed and administered by the State health agencies and approved by the Children's Bureau"—which indicates that it was the original intention of Congress that the plans be formulated and carried out by the various State Departments of Health. It was never intended that the Children's Bureau should lay down plans for the entire United States and its possessions.

### "SOMEWHAT OF A MESS"

Although Dr. Rice believes that the personnel of the Children's Bureau is sincere he characterized the whole situation as "somewhat of a mess." Both the Bureau and Congress have made certain fundamental mistakes and now the blame has been pushed over on to the physicians. The State Departments of Health have experienced a tremendous amount of work trying to keep up with the changing rules of the program. The Advisory Committee came in for considerable criticism. What is needed is not a committee of leftists nor a lot of high powered obstetrical men but men who are trained in administration. By its rules laid down in the program the Children's Bureau has created distrust between physician and patient. The principal benefit to be derived from EMIC is in the fact that this is the guinea pig serving to show everyone what a predicament would be produced under a complete Federal health program. It has cost $42,800,000 to date for EMIC. What would be the cost if the Wagner-Murray-Dingell bill were passed?

### THE REMEDY

Each physician should write his Congressman informing them that the Children's Bureau has precipitated a very dangerous program and request Congress to break the strangle hold the Bureau has secured. As now set up, EMIC is a violation of the 10th Amendment to the Constitution of the United States in that it is a Federal agency administering State funds.

### MEDICAL CASH INDEMNITY VS. SERVICE PLANS

Time prevented a discussion of the relative merits of cash indemnity and inclusive prepaid medical service plans. Robert E. S. Young, a member of the medical service committee of the Ohio State Medical Association presented a brief for the cash indemnity plan but in doing so stepped quite squarely on the toes of both Michigan and California which have been operating service plans for some time. Dr. Young emphasized the fact that cash indemnity plans fix a minimum fee, whereas service plans fix the maximum fee which a physician may charge. Pro-rating of fees often occurs under a service plan and there is also the danger of a third party intervening. Dr. Young called attention to the fact that service plans are based on a stable value of the dollar and on regular employment and warned against the difficulties of operation to be expected when unemployment becomes general and trade unions insist on continued operation of the plan. Ohio has a non profit stock company owned by physicians but not connected with the State Medical Society. The Ohio State Medical Society rejected the idea of a mutual benefit company because of the fear that the control of proxies might fall into union hands. Dr. Young advocated the establishment of a chair in our medical schools to teach medical economics, and the inclusion of medical students in our county societies to stimulate interest in this phase of medical practice.

### MICHIGAN AND CALIFORNIA OBJECT

Both Dr. Haughey of Michigan and Dr. Kress of California objected to many of Dr. Young's criticisms of the service plan for prepaid medical care. Michigan and California have furnished the actual experience with this type of plan and have withstood the vicissitudes falling to the lot of the pioneer. Dr. Kress believes the cash indemnity plan will lead only to disaster when the Federal government tries to take over. The troubles in the service plan as experienced in California are not with the laity but within the medical profession. Dr. Haughey outlined Michigan's experience, going through financial difficulties because of too inclusive a plan, and now solvent and able gradually to restore some of the deleted service. Physicians throughout the United States, according to Dr. Haughey, should join the American Legion where eligible in order to help mold public opinion in the coming post war period.

### NATIONAL FITNESS PROGRAM

The second morning of the conference afforded an opportunity to hear in detail of the contemplated national fitness program from J. W. Wilce of Ohio State University, a member of the National Committee on Physical Fitness. Dr. Wilce called attention to the fact that to be physically fit is more than being healthy. Medicine's task centers around the

recognition of physical and mental defects as a fundamental basis for physical fitness. In this new program to make the youth of our nation physically fit a committee of physicians and physical educators has been named, this committee not at present a Federal agency. A medical affiliates sub committee of local and state members has also been appointed but at this time has not yet had any meetings. Medicine has been notoriously conservative in its approach to this program and a variety of objections to it have been raised by individual physicians. If this program is not given proper medical guidance there is danger that it may go into reverse and do harm rather than good. It should be a total and continuing movement instead of confined to only one year as has been proposed by some. The capacity for fund raising from industry to back the plan is tremendous. The program must be effected through organizations on the local level.

### MEDICINE IN STRATEGIC POSITION

Dr. Fishbein, in discussing Dr. Wilce's paper, called attention to the fact that the hearings before the Pepper Committee in Washington are likely to be a political football with the finger leveled at the medical profession for the Selective Service rejections. We are now in a fine strategic position to prove to the public that medicine is interested in improving the nation's physical fitness. The various State governors have been requested to set up State committees to guide this movement with adequate representation from the State Medical Societies. All the industries concerned in the health field will establish the necessary funds to be given to a foundation which will be under medical control. It is planned that this nationwide physical fitness program reach the industrial worker as it is at that level where physical fitness begins to degenerate. It is essential that the family physician be educated in the program of health examinations.

### RADIO BROADCASTING

The Michigan State Medical Society is probably unique in its purchasing of broadcasting time to advertise medicine to the public. A. S. Brunk, president of the Michigan Society, discussed the plan as it has been carried out in that State where a special tax was levied on each member of the State Society and regular time purchased for radio broadcasting. Michigan physicians have spent $10,000 during the year for this program under the supervision of a special committee. Radio stations covering the entire state were utilized and five minute dramatizations of an educational nature were broadcasted. This was carried on from August 1 to November 15 and is estimated to have reached an audience of 1,250,000 people or approximately 20 per cent of Michigan's population. This method of purchasing broadcasting time makes possible the selection of a more desirable hour than may be obtained by a medical society on free time.

### FUNCTION OF JOURNALS

At the dinner meeting of the editors, three excellent discussions of the functions of the State medical journal were presented. Herman M. Jahr, editor of the Nebraska Journal, called attention to the influence of editorials in molding opinion. Creighton Barker discussed the attitude our state joursals should maintain toward political and social trends affecting medical practice. E. M. Shanklin, editor of the Indiana Journal, emphasized the value of news in our journal. Each speaker contributed from his experience, making the program of value.

### COOPERATIVE MEDICAL ADVERTISING BUREAU

Your editor as a member of the Advisory Committee of the Cooperative Medical Advertising Bureau attended three meetings of the committee during the conference, two of them being with the Board of Trestees of the A. M. A. Two new members have been added to the Committee, John S. Bouslog, secretary of Colorado State Medical Society, and L. Fernald Foster, secretary of Michigan State Medical Society. The Committee is endeavoring to work out a solution of the present advertising problem in order that all the state journals may be self supporting. There is available considerable advertising of good, widely used products which have not been accepted by any of the councils of the American Medical Association. Many of the state journals would like to carry some of this advertising but have hesitated because of the requirements of the Cooperative Medical Advertising Bureau. The problem still remains for solution.

# CHILD HEALTH IN THE POST WAR PERIOD

The American Academy of Pediatrics, in accepting the report of a special committee on the consideration of child health in the post war period, advocates the development of a broad program of child health services which "will fit into any type of overall program for medical care which may be evolved."

The report of the committee, which was comprised of three representatives each from the American Academy of Pediatrics, the American Pediatric Society and the Medical Advisory Board of the Children's Bureau, bases its seven recommendations on an analysis of the inadequate and inequable distribution of pediatric care under present conditions. In the opinion of the committee, preventive and curative pediatric care of high quality is not received by a large number of children for three major reasons:

1. The services are not generally available where they reside because of lack of personnel and facilities.
2. The parents are unable to pay for the services.
3. There is unwillingness to use, or lack of knowledge of available facilities.

Lack of personnel—physicians, nurses, health officers and technicians—and lack of facilities including hospitals, health centers, well child conferences and health departments are listed as the primary causative factors underlying the first problem. Stress is laid, however, not merely upon the requisite increase in numbers of personnel but also and especially upon the equal importance of providing more adequate pediatric training in medical and nursing schools, hospitals and clinics, for specialists, general practitioners, nurses and health officers. In like manner, it is stated that expansion in physical facilities for child care must be accompanied by careful plans for districting and for coordination and integration with existing sources of services.

Other measures believed by the joint committee to be essential in attaining the objective of adequate and accessible pediatric care are proper remuneration of personnel, which is strongly emphasized; support of pediatric research and prompt application of new knowledge and techniques in pediatric practice; and correlation of housing, education, recreation and nutrition with any program relating to child health.

The significance of the report lies in the several recommendations which have been formulated as a result of the study of these fundamental problems. The first recommendation: viz., that intensive surveys be undertaken in every state to determine the number and distribution of children; of pediatricians and of general practitioners graduated since 1930; of hospital, health center, clinic and health department facilities; of public health and pediatric nursing; of medical social services and school health services is obviously of potential practical value provided such surveys are uniformly thorough and competent.

An equally sound proposal is the second which advocates sponsorship by the Academy of efforts to increase and expand facilities for better pediatric training through postgraduate courses, employment of full time pediatricians as teachers and consultants in state health agencies for areas without pediatricians and with high mortality rates, integration of obstetric and pediatric hospital and clinic services and emphasis on both preventive and curative care.

In dealing with the question of administration of Children's Health Services, it is recommended that physicians, agencies and the people at the local level determine the administrative organization and that there be no remote control on the state or federal level.

The financing of such a program, it is held cannot be reduced to any one simple formula but may be provided for by fee-for-service, voluntary insurance plans, compulsory insurance plans, state or local taxation, federal grants-in-aid or by a combination of methods.

As its final recommendation, the Academy supports the establishment of a National Department of Health and Welfare of cabinet rank, which would serve to correlate all health and welfare activities at the federal level.

The report of the joint committee is timely, provocative and deserving of careful study in view of the current preoccupation of medical and non medical persons and organizations with the development of plans for medical care.

## Horace Wells Takes His Place Among the Great

Monday, December 11, 1944 will go down in the annals of the Connecticut State Dental Association as marking one of the most impressive and brilliantly successful events in its history. The Horace Wells Centenary Committee with Eugene M. Clifford as chairman may well feel gratified as it reviews the culmination of its efforts. It has placed the figure of Horace Wells on a high pedestal in the Hall of Fame and brought new lustre to the dental profession in this State. Commencing with the dignified yet friendly dinner of the Horace Wells Club at the Hartford Club Sunday evening, the well balanced, smooth running program studded with stars of the dental and medical professions, made a rich background for the occasion. It was representative of the City of Hartford, where Horace Wells lived and practised his profession, of the State of Connecticut, of the United States and of international interests. Each event is worthy of special mention because it had in it not only deep historical significance but a picture of the future, colored with high promise and hope.

Practically every newspaper in the State and many outside reported the occasion. Of particular interest to members of the Connecticut State Medical Society should be the following notes:

AT THE HUNT MEMORIAL—Comfortable and commodious quarters housing The Hartford Medical Society, gift in 1897 of Mary Crosby Hunt wife of Ebenezer Kingsbury Hunt who practised medicine in Hartford for over 50 years . . . The large registration under the supervision of busy and capable Earle S. Arnold, secretary-treasurer of the State Dental Association . . . The highly interesting exhibit of ancient and crudely devised anesthesia apparatus arranged in chronological order from the first machines up to the new streamlined models of 1944 . . . This exhibit arranged by Curtiss B. Hickcox, acting chief anesthetist of Hartford Hospital . . . The solemn ceremony (with auditorium lights out) of the presentation of the tablet to be placed on the site of Dr. Wells' house . . . The introduction of Dr. J. Aurelio Ortiz of the Republic of Costa Rica who presented a scroll received by the popular president "Jack" Murren, in language used by august diplomats with Powers Plenipotentiary! . . . The warm devotion to the memory of Horace Wells of Frederic T. Murless, secretary of the Horace Wells Club, telling of the annual dinners of the Society for the past 50 years, now become a matter of rite and ceremony, meeting, once a year in tuxedo attire, partaking of the same menu no matter what, important among the items being mock turtle soup and champagne . . . T. Frank Cassidy's fine reading of Dr. Howard R. Raper's essay on "Glimpses of the Man Horace Wells," an appealing picture with rather intimate glimpses such as Horace Wells' "scientific" romance . . . Morton J. Loeb's enthusiastic introduction of Samuel C. Harvey . . . his essay, easily one of the most comprehensive and outstanding of the meeting, a very complete and true picture of the parallel development of anesthesia and asepsis . . . Some choice Harveyan phrases: "Then began the invasion of the abdomen;" "Cutting with a heavier hand;" "Autopsy on living tissue;" "Chasing an eye" without local.

IN THE AFTERNOON SESSION at the Hartford Club . . . Governor Baldwin's stentorian tones . . . His grave digger's story done in an Irish brogue . . . His tribute to the doctors' work at the Circus fire . . . Dentists identifying casualties at the Armory . . . Future plans of the State in TB care and for the mentally ill . . . Robert W. Strang's toastmastering . . . H. Gildersleeve Jarvis' sincerity and his beautiful allusion to the Horace Wells stained glass window in Center Church . . . a tribute indeed was Arthur H. Merritt's speech . . . The happily chosen words of Arthur L. Walsh in bringing greetings from Canada . . . His application of the Victoria Cross and his charm of manner and diction . . . Then the radio hook-up with Walter Scherer giving a minute biography of Horace Wells . . . Finally, General Parran . . . He always seems to speak *ex officio* . . . in splendid voice . . . displaying overflowing knoweledge of his subjects . . . a splendid outline and a broad preview of the Government program . . . much of it being worked out with the American Dental Association.

## Connecticut Public Health Association Meets

The fall meeting of the Connecticut Public Health Association was held in conjunction with the semi-annual health officers' meeting on Wednesday, November 29, at the Waterbury Medical Association Building.

Mrs. Evangeline Morris, assistant professor at the Simmons College School of Nursing, was the speaker at the morning session which was well attended by public health nurses, health educators and social workers. The functions of the public health nurse in a venereal disease control program were clearly defined by Mrs. Morris who emphasized the need for awareness and understanding by the nurse of social situations which promote casual moral attitudes and promiscuity. Following the talk, "To the People of the United States," a film on syphilis control for use in the education of lay groups, was shown under the direction of the Bureau of Public Health Instruction of the State Department of Health.

Jacob H. Landes, M.D., district health officer, Brooklyn, New York, was the principal speaker of the afternoon session. Dr. Landes described the organization and operation of a cooperative indus-

trial health committee in the Fort Greene section of the borough. With the participation of the majority of medical and health agencies and industrial plants in the area, a progressive and interesting educational program for the promotion of the health of industrial workers has been developed. An effective experiment in group education has been undertaken by the committee in the publictaion of a weekly health tabloid which is distributed free to the employees of all participating plants, factories and stores.

The epidemiological investigation of an outbreak of typhoid fever in the neighborhood of Jewett City was ably recounted by Eugene E. Lamoureux, epidemiologist, State Department of Health.

Paul Phelps, medical director of the State Tuberculosis Commission, introduced the question of the control of the recalcitrant tuberculosis patient for discussion. It was voted to refer the problem of legislation on this matter to the Executive Committee of the Public Health Association.

## Conference of Social Workers Hears Dr. Goldman

At the Connecticut Conference of Social Workers held in New Haven on November 16 there was a presentation of proposed broadening of medical features of the Social Security program. Alfred L. Burgdorf, health officer, Hartford, was chairman. The speaker was Franz Goldman, associate professor of public health, Yale School of Medicine.

In his paper on "An Adequate Medical Program for the Nation," presented before a capacity audience, Dr. Goldman had marshalled a plethora of facts on existing social and economic systems and displayed a broad and ready knowledge of the subject. Many points were of a highly controversial nature. About these Dr. Goldman was very articulate and earnest but he was very determined in discussions which followed to stand in a neutral position. His paper is epitomized in a press release quoted as follows:

"Medical care, adequate in quality and quantity, should be available to all the people without discrimination and at a price fair to all. The attainment of this objective requires planning—planning for: (1) hospitals and health centers serving the community; (2) organized professional services with emphasis on quality; (3) methods of payment for both the establishment of necessary facilities and the services rendered by institutions and health professions; and (4) administrative procedures to assure early diagnosis; early, prompt and thorough treatment; high standards of service; and continuity and consistency of care. They are all parts of an integral whole and cannot be separated without injuring all. Any legislative proposals for a nationwide health program should include these four elements."

## Staff Meetings On Intern Education

On Wednesday, November 15, the first of a newly established program of staff meetings in the interests of intern education was held at the Hospital of St. Raphael, New Haven. Thomas P. Murdock, chief of staff of the Meriden Hospital was the principal speaker. After analyzing conditions as they now exist generally, he gave a vivid description of the Meriden plan now successfully in operation.

At the second meeting held Wednesday, November 29, Creighton Barker, executive secretary of the Connecticut State Medical Society, gave the meeting some "outside" facts pertinent to the situation which hospital staffs are facing today. He stated that there are between 700 and 1,000 vacancies, described the functioning of the War Manpower Commission and the prospects of post war conditions. In summing up, Dr. Barker spoke encouragingly about what can be accomplished at St. Raphael's Hospital and outlined in general terms how this could be done.

## Cancer Group at New Haven

Fifteen persons met at the Hotel Taft in New Haven, Thursday, November 16, to discuss plans for the formation of a New Haven Chapter of the Connecticut Cancer Society. Among the speakers were A. N. Creadick of New Haven, chairman of the State Cancer Society; Samuel C. Harvey, professor of surgery at Yale Medical School; William Mendelsohn, chief of the cancer clinic at Grace Hospital; Grace Mooney from the secretary's office of the State Medical Society; and Creighton Barker, executive secretary of the State Medical Society. Following is a report of the meeting as printed in the *New Haven Register* of November 17:

The immediate objective of the chapter, which is headed by Mrs. George Hodson, will be to educate the public that cancer, if detected in time, is curable. This message will be carried by doctors and others who will be members of a Speakers' Bureau and will talk before factory groups, fraternal organizations, schools and other assemblies. The aid of the press and radio will be solicited. Literature, written in simple language and devoid of professional medical terms, will be distributed.

No drive for funds to finance the work will be made until April. Then it is hoped to receive at least 3,000 subscriptions at $1 each.

Deaths due to cancer are rising sharply and, from the present trend, Dr. Mendelsohn predicted, the rate five years from now will be double what it is today. Oddly, it was pointed out, the higher number of cancer deaths is due to advances made in the control of other diseases and the extension of the normal life span. Persons, who a decade ago would have succumbed to ailments which were then not easily cured, now survive to fall victims later to cancer.

Cancer, if detected early, can be cured in a high percentage of the cases, it was said. The best way to detect it, is through examinations by competent physicians and these periodical visits were recommended. It is rare, the doctors said, that a person voluntarily visits a cancer clinic and asks for an examination. Practically all who report at the City clinics are referred there by physicians who, examining ill persons, have noted symptoms of the disease.

James Swain Cooper, New Haven, head of the Fuller Fund, which makes money available for cancer study and treatment, was present at the meeting and engaged in a discussion on the economic angles of the plan.

Mrs. Hodson was hostess at a dinner which preceded the meeting.

## New Group to Advise On Infantile Paralysis

Basil O'Connor, President of the National Foundation For Infantile Paralysis, Inc., Washington, D. C., recently called for the establishment of a Medical Advisory Committee to serve the New Haven County Chapter, Joseph I. Linde, M.D., Chairman, announced that the Executive Committee had nominated the following:

Creighton Barker, New Haven, executive secretary of the Connecticut State Medical Society; Miss Jessie Halbert, Meriden, director, Meriden Visiting Nurse and Public Health Association; William C. McGuire, New Haven, pediatrician, Hospital of Saint Raphael; Thomas P. Murdock, Meriden, internist, Connecticut State Medical Examining Board; David Poverman, New Haven, orthopedist, Grace Hospital; Grover S. Powers, New Haven, pediatrician, New Haven Hospital; Herbert Thoms, New Haven, councillor, State Medical Society; Miss Catherine J. Wellington, New Haven, supervisor, Crippled Children's Aid Society of New Haven. The Committee will serve as a body or individually depending upon circumstances.

Last year the New Haven Chapter spent $32,518 on acute and convalescent cases. In addition $725 was expended on braces, and $380 on physiotherapy. Nurses and physiotherapists were paid $10,925. The Chapter assisted financially in over 100 cases. Plans have been developed and a routine established for home treatment and in convalescent homes.

## National Foundation Head Visits Hartford

Emphasizing the function of the local chapters of the National Foundation for Infantile Paralysis as being primarily that of spending money rather than acquiring it, D. Basil O'Connor, its national president, addressed a dinner meeting of representatives from all over Connecticut at the Hartford Club on December 1. Mr. O'Connor, who is also chairman of the National Committee of the American Red Cross, presented a kaleidiscopic picture of the fields in which the National Foundation is engaged: viz., research, epidemic and public health, education, and the after effects of research. He emphasized the number and size of research grants, both short and long term, made possible by the Foundation.

Of particular interest to physicians were Mr. O'Connor's remarks concerning grants in the field of physical medicine and in particular the financing of the Kenny method of treatment. The Foundation, in order to determine the value of this method, financed its program of teaching for eighteen months at the University of Minnesota, and later in eight other institutions. A total of 988 physicians, nurses and physical therapy technicians have taken this course with an outlay of about $1,000,000 by the Foundation and $3,000 to $4,000 by local chapters. The acrimonious debate which has arisen over the value of the Kenny method of treatment has produced beneficial results, according to Mr. O'Connor.

In speaking for the Mile of Dimes campaign in Connecticut, Mr. John M. Hurley, state director of organization of the National Foundation for Infantile Paralysis, Inc., reminded his audience that this State raised $301,000 in the 1944 campaign, a per capita contribution of 17 cents. No other state in the Union equalled this record, New York contributing 7 cents per capita, Illinois 4½ cents, and Massachusetts 12 cents.

## National Physicians Committee Discusses Cooperative Group Insurance

Declaring that voluntary group insurance to provide sickness and death benefits and protection for employees against the hazards of hospitalization and surgical care costs has become a "must" for business and industry in the United States, the National Physicians Committee sponsored a conference in

New York City on November 27 for the declared purpose of examining and evaluating Industry Group Insurance programs in terms of management's approval and employee benefit and satisfaction. The Conference called together leaders of medicine, insurance and industry to the sumptuous hall of the Waldorf Astoria Hotel. It emphasized the results of the survey recently completed by the Opinion Research Corporation among more than 4,000,000 workers, and pointed out the immense possibility of development in a field in which 83,000,000 persons, or 63 per cent of the population, believed that an easier method of meeting the cost of unusual illness or surgery can be provided.

Dr. Herbert D. Simpson, formerly of the Institute of Economic Research, Northwestern University, stated that he considered it no longer a question of individual medicine, that the choice now lies between two types of institutional medicine, governmental or private, and that it has now become a question of the ability of private enterprise to meet its responsibility and preserve its own survival.

The Conference dangled before the representatives of insurance the profits to be gained by seizing this opportunity to push group insurance against illness among industrial employees, in fact, it seemed to be financial profit in commercial insurance rather than medical care which received all the emphasis. Some of the speakers expressed the belief that commercial insurance against illness would be one way of preventing the enactment of legislation providing for Federal control of medical care.

The survey made for the National Physicians Committee by the Public Opinion Research Corporation, while it does reveal the expressed demand on the part of the public for better protection against the hazards of day to day emergencies, does not present any clear public opinion as to just how this protection can be best secured. An appreciable proportion of the population polled was found to have little knowledge of prepayment plans for industrial employees and a considerable number had no opinion of how payment of physicians and hospital bills might be made easier.

*The New York Times* expressed disappointment that the Conference did not clarify the confusion existing in its mind as to who should control medical care plans. The public was not heard from, neither was the general practitioner at this Conference. There is a crying demand for a PLAN that will include everyone, some such Utopian arrangement as Major LaGuardia and the Federal Social Security leaders seem to have in mind. Of course the Conference didn't fulfill this demand. It was presenting but one method of meeting the costs of medical care, by cooperative group insurance.

## Money Needed For Cancer Research

The American Cancer Society will ask leaders of organized labor to help to direct its forthcoming nationwide drive for $5,000,000 for cancer research.

Dr. Frank Adair, president of the society, made this announcement at the two-day regional meeting of the New England district held in Providence, November 28 and 29. He added that the money must come from working people if the goal is to be reached and stated that in response to an appeal issued in a nationally circulated magazine, $25,000 in dollar bills was received. Dr. Adair pointed out that until three years ago, there would have been no justification for a public appeal for funds for research because nothing had been uncovered as a basis for study. Within that period, he continued, "clues have been found which are sufficient to justify the appeal."

Dr. Adair described cancer as the biggest peacetime health problem of the day, citing that the disease killed 164,000 persons in 1943 and more than half the victims were women. He also pointed out the high incidence of cancer among veterans in military hospitals.

Although there are now 400 clinics in the country, approved by the American College of Surgeons, and public education regarding the disease is spreading rapidly, he said funds are badly needed for research. "The education of the public is going forward so much faster than the education of the doctor that there is no comparison," he declared. He said that with the war time shortage of doctors the program of cancer detection will probably lag until the war is over, pointing out the obvious difficulty presented when a physician is asked to make a careful examination of a patient who may have nothing wrong with him while fifty in immediate need of care wait in his office.

Mrs. Harold V. Milligan, national director of the society, pointed out the high prevalence of cancer in her talk, given on the second day of the session. She stressed its effect on the manpower shortage because the disease is most prevalent among women between the ages of 35 and 55 who, if not afflicted, might be working. She also said that the inability of

women stricken with the disease to care for their adolescent children might be a contribution to juvenile delinquency.

Miss Emily Sheldon of Rutland, Vt., described the techniques of teaching biology to younger people in the schools. She also discussed the warning signs of the disease and the importance of early diagnosis.

Mrs. James C. Carmack of Providence, regional director, presided at a round table discussion during the assembly at which Mrs. Milligan and the following state commanders were present: Mrs. Harold Cooper, Maine; Mrs. Harry W. Smith, New Hampshire; Mrs. Charles B. Adams, Vermont; Mrs. Douglass O. Burnham, Connecticut; Mrs. Harry P. Van Wagenen of New York. Mrs. Francis J. Rigney of New York City was also present.

## State Physical Therapy Centers

Twenty physical therapy centers conducted by the physical therapy technicians of the Division of Crippled Children of the Bureau of Child Hygiene are available to crippled children in various parts of the state. Children living in those areas of the state not indicated here (Middlesex and Hartford counties) can receive physical therapy treatments through sources other than state technicians, for example, at the Newington Home for Crippled Children, the Middletown District Nurse Association and at local hospitals.

There are also many local resources within those counties where state physical therapy services are available as well as at physicians' offices. To serve all the crippled children in the state these local resources as well as the state are essential.

LITCHFIELD COUNTY

Torrington: Charlotte Hungerford Hospital, Monday P. M. and Friday A. M. and P. M.

Winsted: Anna Hadley Hakes Clinic, Thursday A. M. and P. M.

Thomaston: Public Health Nursing Association, Tuesday A. M.

Watertown: Red Cross Headquarters, Tuesday P. M.

FAIRFIELD COUNTY

Danbury: Danbury Hospital, *Thursday P. M.

Stamford: Stamford Hospital, Tuesday A. M. and Friday A. M. and P. M.

Norwalk: Norwalk Hospital, Tuesday P. M.

Monroe: Monroe School, Thursday A. M.

NEW HAVEN COUNTY

Naugatuck: Red Cross Headquarters, Monday A. M. and P. M.

Derby: Griffin Hospital, Wednesday A. M. and P. M.

TOLLAND COUNTY

Stafford Springs: Visiting Nurse Association, Alternating Wednesday P. M.

Rockville: Visiting Nurse Association, Alternating Wednesday P. M.

WINDHAM COUNTY

Willimantic: Windham County Memorial Hospital, *Wednesday A. M.

Putnam: Day Kimball Hospital, Tuesday A. M. and P. M.

Plainfield: Plainfield School, Thursday A. M.

Moosup: Moosup School, Thursday P. M.

North Grosvenordale: St. Joseph's School, Thursday A. M.

NEW LONDON COUNTY

Norwich: William W. Backus Hospital, *Monday A. M. and P. M.

New London: New London Clinic, Wednesday P. M. and Friday A. M. and P. M.

Jewett City: St. Mary's School, Wednesday A. M.

*Children also treated by the hospital technician on other days

This States the Case for Professional




Season's Greetings
to our many Connecticut doctor and hospital friends

# MEDICINE AND THE WAR

## Pay Allowances For Women Medical Officers

Legislation under which women officers of the Army Medical Corps will be entitled to receive the same pay allowances for their dependents as are paid to all other commissioned personnel of the Army became effective on October 1.

An act authorizing the commissioning of women physicians in the Medical Corps was approved in April 1943, and provided that they should "receive the same pay and allowances and be entitled to the same rights, privileges and benefits as members of the Officers Reserve Corps of the Army." The Comptroller General subsequently ruled that they were not entitled to allowances for dependents.

The new law, designed to meet the Comptroller General's objections, is not retroactive to the date of women officers' commissions. The dependents for whom allowances may be paid are "husband, a child or children, or a parent or parents in fact dependent" upon the officer "for their chief support."

Approximately 75 women have been commissioned to date in the Medical Corps.

## War Medicine: Vol. 6, No. 4, October 1944

This issue of *War Medicine* renews the old discussion of neurocirculatory asthenia of World War I in an article by Major Meyer Friedman, MC—AUS, entitled "Etiology and Pathogenesis of Neurocirculatory Asthenia: 1. Hyperthermia as One of the Manifestations." The author comments on the episodic type of fever in this condition and suggests the possibility that there is hypothalmic dysfunction in this syndrome. "Problems of Naval Psychiatry" is discussed by two naval physicians and attention is called to the distinct difference in these from the usual psychiatric problems. They conclude that ninety per cent of the group discharged for inadequacy and emotional instability should adjust well in civilian life. "Psysiologic Effects of Drinking Undiluted Sea Water" by J. R. Elkinton, M.D., and A. W. Winkler, M.D., of Yale University School of Medicine emphasize the danger of resulting dehydration affecting both intracellular and extracellular fluid. The intracellular dehydration in the extreme produces disturbances of the nervous system with terminal respiratory failure.

Other articles appear on "Effect of Sulfonamide Drugs on Experimental Gunshot Wounds of Peripheral Nerves" by three Chicago physicians; "Immunity to Diphtheria in Army Personnel" by two Army physicians; "Use of Industrial Incentives in War Production of Medical Material" by Captain E. R. Eaton, MC—USNR; "Bacillary Dysentery" by Major H. M. Hurevitz, MC—AUS; "Mediastinal Emphysema Resulting from Exposure to a Pulmonary Irritant" by two Army physicians; and "A Simple and Rapid Method of Destroying Crab Lice: Report of Its Use in Twelve Cases in the South Pacific" by Lieutenant Commander Dayton O'Donnell, MC—USNR.

The twenty-eight pages of Abstracts from Current Literature are entirely from British and American journals. Four book reviews, three American and one British, complete the issue.

## Commissions — Changes in Station

Lt. (j.g.) Robert R. Berneike, New Haven, was commissioned in the Navy October 9, 1944, and assigned to the U. S. Naval Hospital, Naval Operating Base at Norfolk 13, Virginia.

1st Lt. Seraphino P. Tombari, MC—AUS, Hartford, has been transferred from Fort Rliey, Kansas, to Camp Barkeley, Texas.

Captain J. Henderson, Stamford, has been transferred from the Wakeman General Hospital at Camp Atterburg, Indiana to Camp Barkeley, Texas.

Benjamin B. Whitcomb, Hartford, stationed at the Walter Reed General Hospital in Washington, D. C., has been promoted to the rank of Captain.

Capt. Harold A. Bergendahl is now on sick leave and recently stopped in at the Society's headquarters in New Haven.

Donald M. F. Biehn, Fairfield, has recently been promoted to Captain.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Captain B. B. Whitcomb, Hartford

Washington, D. C.,
November 26, 1944

I was chagrined to find a letter written to you August 20, 1944 that had never found the mail box—so much the better for the Army-Navy issue since it will leave more space for more interesting reports. The Army-Navy issue of last year was one of the best periodicals out. The experiences of friends and acquaintances were of absorbing interest. Mine are quite drab in comparison.

My military service has been spent at the Walter Reed General Hospital in Washington where I have been on the neurosurgical service. This is a neurosurgical center and our work is practically all confined to rehabilitation neurosurgery. It gives one an excellent opportunity to see what our confreres have done in the forward areas and we feel quite humble when we receive soldiers like a recent admission wounded in the European theatre who lost one arm, had a compound, comminuted fracture of left lower leg, had undergone an operation on the field where his liver had been packed, the spleen removed, one kidney sutured and six perforations of the stomach and gut sutured. Referred to us for suture of his remaining radial nerve!—and I forgot to mention the hemothorax and perforation of the diaphragm. Many times, however, our work is not so much the minor part of the picture and the peripheral nerve lesions and skull defects present major elective surgical problems. There are between 450 and 500 patients on our service with a surprisingly rapid turn over except for the peripheral nerves. These patients require infinite patience and physical therapy for months but these appear rewarded when the nerves blossom into function 8 to 14 months after suture.

Because of the large number of civilian dependents of military personnel in and about Washington, this service is not unlike a large civilian general hospital with many brain tumors—occasional abscesses and frequent acute head injuries, ruptured discs, etc. The battle of Washington is not always as easy as it might appear. The Walter Reed General Hospital being so near to so many headquarters and because of its central location is an enviable spot to run across old friends both among the military and civilians. One also sees many interesting things—some medical—others not. I have seen here:

—A soldier shot completely through the head without obvious damage.

—An army officer whom I presented before the retirement board following a radical perineal prostatectomy for carcinoma of the prostate returned to full duty—while the next officer was retired because of foot strain.

—More generals than lieutenants.

—A sutured brachial plexus pick up a pin a year later.

—Doctors Claude Kelly, Ed, Clint and Clyde Deming and Dr. St. John making rounds at Walter Reed.

—Too many malignant brain tumors in young soldiers.

—A Cadillac with 4 stars parked again and again beside my '37 Ford at Walter Reed. Am I being followed?

—Mun Romansky of Hartford develop the "one shot" cure for gonorrhoea.

—Head injuries and ruptured discs ambulatory on the first post op. day.

—A amputé, with both legs disarticulted at the pelvis, walk on prostheses, while another with bilateral amputations of the upper extremities played ping pong—and well.

—One-third of the entire calvarium replaced by a tantalum plate.

—5 paraplegias, considered hopeless, regain voluntary motion in their legs months after receiving their spinal injuries.

But the other day when I saw the owner of the *New York Times* gleaning his news from a tabloid I figured I had seen everything.

I am sorry my report is too late for the Army-Navy number but I'm sending it on to be on the record and let you know what we are doing. You are doing a swell job keeping the JOURNAL going with all your added work and we appreciate them all. Please drop in to see us at Walter Reed if you are down this way.

Ben Whitcomb

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## CONNECTICUT 1945

Governor, Raymond E. Baldwin (r), Stratford

Lieutenant-Governor, Wilbert Snow (d)
Middletown

Secretary, Charles J. Prestia (d)
New Britain

Treasurer, William T. Carroll (d)
Torrington

Comptroller, John M. Dowe (d)
Killingly

### The Congress of the United States

### The Senate

Francis Maloney (d), Meriden

Brien McMahon (d), Norwalk

### The House of Representatives

1st District, Herman P. Kopplemann (d)
Hartford

2nd District, Mrs. Chase Going Woodhouse (d)
New London

3rd District, James P. Geelan (d)
New Haven

4th District, Clare Booth Luce (r)
Greenwich

5th District, Joseph E. Talbot (r)
Naugatuck

At-large, Joseph F. Ryter (d)
Hartford

### The State Senate

| *District* | *District* | *District* |
|---|---|---|
| 1–William A. Scott (d)* | 13–Harold C. Hall (d) | 25–William E. Sheehy (r) |
| 2–Nathan Aaron (d) | 14–William A. Painter (r) | 26–Alfred Tweedy (r) |
| 3–Leon Riscassi (d)* | 15–Edward P. Egan (d) | 27–Vincent Giampietro (r) |
| 4–William E. Hanmer (r) | 16–Patrick J. Wallace (d) | 28–Henry F. Joy (r) |
| 5–Robert E. Parsons (r)* | 17–Vincent P. Kiernan (d) | 29–Margaret C. Hurley (d)* |
| 6–Matthew J. Avitabile (d) | 18–Richard F. Corkey (d) | 30–Alex G. Constable (d) |
| 7–Charles H. Vincent (r) | 19–Nicholas J. Spellman (d)* | 31–John J. Barry (d) |
| 8–James E. Foley (d) | 20–Robert H. Winslow (r) | 32–Amos H. Lister (r) |
| 9–Samuel H. Malkan (d)* | 21–Benjamin Leipner (d) | 33–John J. Monnes (d) |
| 10–William F. Lynch (d) | 22–Albert L. Coles (d)* | 34–James U. Dibble (r) |
| 11–B. Fred Damiani (d) | 23–Cornelius Mulvihill, Jr. (d)* | 35–Eugene W. Latimer (r)* |
| 12–C. Raymond Brock (r)* | 24–Alice Rowland (r)* | 36–Edward L. Fenn (r)* |

*Denotes incumbent–(12)

Seating: Democrats, 20; Republicans, 16

1943 Senate: Republican 22; Democratic 14

## The House of Representatives

Andover, George A. Merritt (r)*
Ansonia, Edward G. Clancy (d)*; Arthur A. Gaudio (d)
Ashford, Thomas Supina, Jr. (d)*; John Juhasz, Jr. (d)*
Avon, C. Frederick Woodford (r)
Barkhamsted, Prosper F. Lavieri (r); Alcott C. Rowley (r)*
Beacon Falls, Clara O'Shea (d)
Berlin, James B. Ellsworth (r)*; Stephanie Kamenski (r)*
Bethany, Stanley H. Downs (r)*
Bethel, Herbert B. Wanderer (r)*
Bethlehem, Albert H. Maddox (r)*
Bloomfield, Harold J. Watkins (r)*; H. Ward Pinney (d)
Bolton, Maud L. Woodward (r)*
Bozrah, Gilbert Johnson (d)
Branford, Irving C. Jacocks, Jr. (r)*; Raymond F. Barnes (r)
Bridgeport, Milton J. Herman (d)*; Jane J. Tedesco (d)
Bridgewater, William M. Curtis (r)*
Bristol, Helen Zzikowski (d)*; James P. Casey (d)
Brookfield, Curtis H. Dickens (r)*
Brooklyn, Fred F. Maynard (d)*
Burlington, James B. Mullen (r)
Canaan, Joseph A. Hamzy (r)*
Canterbury, Nelson L. Carpenter (r)*; Alexander Ritz (r)*
Canton, Harold W. Humphrey (r)*
Chaplin, Alvah W. Miller (r)*
Cheshire, Luke H. Stapleton (r); Henry Gund, Jr. (r)
Chester, Charles McKew Parr (r)*
Clinton, John L. Eliot, Sr. (r)*
Colchester, Rubin Cohen (d)*; Charles Shailor (d)*
Colebrooke, Erving Pruyn (r); Earl W. Smith (r)
Columbia, Clayton E. Hunt (r)
Cornwall, Thomas E. Marston (r); Miner P. Rogers (r)*
Coventry, George G. Jacobson (r); Leon H. Austin (r)*
Cromwell, Hjalmar N. Johnson (r)
Danbury, Jeremiah D. Scully (d); Edward F. Smith (d)
Darien, Edward H. Delafield (r); Thomas O'Connor (r)*
Derby, Alton Degnan (d)*; Frank Pepe (d)*
Durham, Richard C. Parmelee (r); Mary R. Arrigoni (r)
Eastford, Herold W. Barrett (r)
East Granby, Beula P. Granger (r)
East Haddam, Raymond T. McMullen (d)*; John Blashick (d)*
East Hampton, Howard J. Engel (r); Sidney M. Hallberg (r)
East Hartford, George R. Davies (d); John L. Walsh (d)
East Haven, Robert H. Gerrish (r)*; Charlotte E. Miller (r)*
East Lyme, Fred A. Beckwoth (r)*; Melville Howard (d)
Easton, Willard S. Gillette (r)*
East Windsor, Walter E. Price (r); Albert G. Gottler (r)*
Ellington, Theodore A. Palmer (r)
Enfield, Philip J. Sullivan (d)*; Lawrence D. Griffin (d)*
Essex, J. Frederick Scholes (r)*
Fairfield, Finnette B. Nichols (r)*; Oliver R. Beers (r)
Farmington, Edward C. Swan (r); Louis Shapiro (r)*
Franklin, Arnold P. Manning (r)
Glastonbury, Blanche B. Pitney (r); John Lawrence (d)
Goshen, Clarence A. Vaill (r)*; John A. Minetto (r)
Granby, Tudor F. Holcomb (r)*; Leon D. Goddard (r)*
Greenwich, L. Paul Burke (r)*; Milo A. Mitchell (r)*
Griswold, Napoleon J. Doyon (d)*; John J. Sawicki (d)*
Groton, Thomas L. Hagerty (r)*; Benjamin L. Mull (r)
Guilford, George C. Conway (r)*; Eleanor H. Little (r)
Haddam, Belle D. Russell (r); Albert H. Hubbard (r)
Hamden, Frederick A. Kirk (r)*; John R. Thim (r)
Hampton, Elmer C. Stone (r)
Hartford, Rene R. Dupuis (d)*; Harold E. Conroy (d)*
Hartland, Perry M. Ransom (r); Dwight G. Stone (r)
Harwinton, Henry J. Delay (r)*; Chauncey E. Hutchings (r)*
Hebron, Annie L. Foote (r); Fitch N. Jones (d)
Kent, Thomas Johnstone Boyd (r)*
Killingly, Albert J. Cavanaugh (d); Philip E. Gendreau (d)
Killingworth, A. Leslie Perkins (r); John Heft, Jr. (d)
Lebanon, John E. Burgess (r)*; David Walsh (r)
Ledyard, Edmund H. Lamb (r)
Lisbon, George Helmboldt (r)
Litchfield, Howard Bissell (r)*; Isabel C. Rylander (r)*
Lyme, John E. Russell (r); Carolyn L. L. Cone (r)*
Madison, Frederick H. Holbrook (r)*
Manchester, George E. Keith (r)*; S. Raymond Smith (r)*
Mansfield, John N. Jacobson (r)*; Edwin O. Smith (r)*
Marlborough, Alice Swante Olander (d)*
Meriden, Sophie C. Kline (d); William A. Jacobs (d)
Middlebury, Charles H. Upson (r)
Middlefield, Charles E. Lyman, Jr. (r)
Middletown, Myron J. Konopka (d); Thomas D'Aquila (d)
Milford, Helen M. Smith (r); Noyes L. Hall (r)*
Monroe, William W. Luckner (r)*
Montville, Edward W. Rice (d)
Morris, William C. Weik (r)
Naugatuck, Joseph V. Rosko (d); Daniel J. Walsh (d)
New Britain, Nicholas J. Tomasetti (d)*; Sophie Liss (d)
New Canaan, Nellie D. Stewart (r)*; Ira E. Hicks (r)*
New Fairfield, Clarissa Nevins (r)*
New Hartford, Harris R. Hunt (r)*; Howard H. Spencer (r)*
New Haven, Anthony Avallone (d); Charles Henchel (d)
Newington, Helen L. Warner (r)*; Charles H. Sherwood (r)*
New London, Dorothy M. Satti (d); Perry Shaffner (d)
New Milford, George H. Allen (r)*; James H. Dodd (r)
Newtown, George M. Stuart (r)*; Newton M. Curtis (r)*
Norfolk, Emiline Spaulding (r); Philip Curtis (r)*
North Branford, R. Earle Beers (r)*
North Canaan, James H. Casey (r)*
North Haven, Clarence F. Andrews (r)*; Kingsley T. Leighton (r)
North Stonington, David L. Stillman (r); William F. Morgan, Sr. (r)
Norwalk, Stanley Stroffolino (r)*; George E. Sartain (r)
Norwich, Alfio Urbinati (d)*; Napoleon Pepin (d)*
Old Lyme, E. Lea Marsh, Jr. (r)*
Old Saybrook, George A. Maynard (r)
Orange, Robert J. Hodge (r)*; George E. Clark (r)*

Oxford, Robert Z. Hawkins (r)*
Plainfield, John A. Fanning (d); Adelard Laflesh (d)
Plainville, John E. Lamb (r)*; Milton M. Koskoff (r)*
Plymouth, Ralph A. Seymour (d)*; Stanley Gosinski (d)
Pomfret, Oren A. Weeks (r); John Ellis Pritchard (r)
Portland, Paul N. Bronson (r)*
Preston, Georgana C. Miller (r)*; Henry E. Burke (r)
Prospect, George Cowdell (r)
Putnam, Israel G. Frechette (d); James J. Charron (d)*
Redding, J. Harold Sanford (r)*; Ethel M. Ryan (r)*
Rocky Hill, Andrew Twaddle (r)*
Roxbury, John F. Pickett (r)*
Salem, Joseph E. Swider (d)*
Salisbury, William G. Raynsford (r)*; William B. Barnett (r)
Saybrook, Kathryn Stalsburg (r)*; David Parodi (r)*
Scotland, Henry W. Clark (r)
Seymour, B. H. Matthies (r)*; James B. Baylis (r)*
Sharon, Alexander Jenkins (r)*; Clarence H. Eggleston (r)*
Shelton, Frank V. Crofut (d)*; Patrick J. Walsh (d)*
Sherman, Howard A. Hueston (r*)
Simsbury, Joseph M. Pattison (r)*; William C. Hall (r)
Somers, Julia A. Keeney (r)*; Oliver C. Pease (r)*
Southbury, Robert C. Mitchell (r)*
Southington, Mary E. Flynn (d); John J. Moran (d)
South Windsor, Harry F. Farnham (r)*
Sprague, John J. Fanning (d)*
Stafford, John H. Mullen (r); Melvin C. Cummings (d)
Stamford, Edna A. F. Edgerton (r)*; Daniel F. B. Hickey (r)
Sterling, James H. Marriott (r)*
Stonington, Francis J. Connors (r); Earl B. Lyon (d)
Stratford, Oscar Peterson, Jr. (r); Rose F. Prokop (r)
Suffield, Matthew Leahey (r)*; Bernhard J. Ahrens (r)*
Thomaston, Allan C. Innes (r)*
Thompson, Raymond L. Donnelly (d)*; Donat J. Ducharme (d)
Tolland, Harwood J. Skelly (r)*; Rupert B. West (r)*
Torrington, Virginia Rosi (d)*; Charles L. Jenkins (d)
Trumbull, George A. Clark (r)*; Anna E. Griffin (r)*
Union, Raymond I. Longley (r); George F. Hall (r)
Vernon, Thomas Rady, Jr. (d); Maurice L. Spurling (d)
Voluntown, George H. Davis (d)*
Wallingford, Ferdinand A. Valenti (d)*; Joseph B. Morris (d)
Warren, Guido Lagrotta (r)*
Washington, Robert J. Benham (r)*; William S. Ford (r)
Waterbury, Daniel J. Mahaney (d)*; John A. Membrino (d)*
Waterford, George H. Field (r), James G. Hammond (r)
Watertown, Eugene H. Lamphier (r)*; Arthur Russell (r)*
Westbrook, James J. Eastland (r)
West Hartford, Wallace E. Campbell (r)*; William H. Dallas (r)
Weston, Chester G. Coley (r)
Westport, Helen Warnock (r); Hereward Wake (r)
Wethersfield, Warren G. Willsey (r)*; Burton A. Harris (r)
Willington, Howard W. Pratt (r)*; Charles F. Wochomurka (r)*
Wilton, Lawrence Moore (r)
Winchester, Walter V. Davey (r); Clarence E. Newett (r)
Windham, Napoleon C. Bortolan (d); Florimond J. Bergeron (d)
Windsor, Carlan H. Goslee (r); Hazel Thrall Sullivan (d)
Windsor Locks, Edward J. Lally (d)
Wolcott, Rose E. Wakelee (r)*
Woodbridge, Chester C. Hitchcock (r)
Woodbury, Arthur E. B. Tanner (r)*; Robert O. Judson (r)*
Woodstock, Henry D. Baker (r)*; Donald B. Williams (r)*

*Denotes incumbent (148)
Seating: Republicans, 195; Democrats, 77

## Pharmacy and the Physician

Justin L. Powers of the American Pharmaceutical Association, in an address recently before the Connecticut Association for the Advancement of Professional Pharmacy, expressed the opinion that the pharmacist of tomorrow must supplement his art with an ability to evaluate for physicians new developments in drugs and dosage forms, and interpret to the public scientific advancements relating to drugs which the service pharmacy has to offer. In order to accomplish this, it is Dr. Powers' belief that colleges of pharmacy will have to place an ever increasing emphasis upon organic chemistry, pharmacology, bacteriology and other basic sciences because it appears that the new drugs of the future are going to be largely synthetic organic chemicals, biologicals, and to a lesser extent pure and physiologically active plant principles.

This States the Case for Professional




Season's Greetings
to our many Connecticut doctor and hospital friends

# INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH
C. F. Yeager, M.D., Chairman, Bridgeport

James H. Biram, Hartford
Gerald M. Chartier, Danielson
John N. Gallivan, East Hartford
Cole B. Gibson, Meriden
Albert S. Gray, Hartford
Martin I. Hall, Bristol
Andrew J. Jackson, Waterbury
Robert W. Kaschub, Groton
Robert P. Knapp, Manchester
Arthur B. Landry, Hartford
Eugene F. Meschter, Stamford
Philip J. Moorad, New Britain
Walter N. Nelson, Cromwell
Frank T. Oberg, Bridgeport
John R. Paul, New Haven
Crit Pharris East Hartford
Frank L. Polito, Torrington
William H. Ryder, New Haven
C. John Satti, New London
Paul W. Vestal, New Haven
Ellwood Weise, Bridgeport

## JOINT CONFERENCE WITH STATE MANUFACTURERS' ASSOCIATION

A joint conference on Industrial Health and Safety was held at the Hotel Taft in New Haven, Thursday, December 14, under the auspices of the Connecticut State Medical Society and the Manufacturers' Association of Connecticut, Inc. The meeting was divided into a series of discussion panels: The Physically and Mentally Handicapped; Rehabilitation of the Industrial Worker; Safeguarding the Industrial Worker.

Martin I. Hall, medical director of the New Departure Division of General Motors Corporation, Bristol, spoke at the first panel on "The Industrial Physician's Roll in Examining, Placing and Safeguarding Workers." He discussed the necessity of the physicians being familiar with the working conditions of the plant environment and the physical demands of the job if he is to render greatest service to the employee and employer alike, and outlined the necessary physical examination program, discussing preplacement, periodic, and re-entrance examinations. He stressed the desirability of health education by utilizing all opportunities to consult with employees and through this opportunity to disperse health information at the most propitious time. Personal instructions may be supplemented with short health topics in the plant publications, news letters, posters, and the like.

Philip J. Moorad of New Britain on this same panel discussed the "Mental Problems Affecting Industrial Workers" and their solution, with special reference to veterans. Dr. Moorad said in conclusion that it was obvious that industry has among its employees a surprisingly large number and variety of mental illnesses, and because of no care or plan for the problems that entail, they go unrecognized causing an alarming number and type of difficulties which handicap smooth and efficient operation of the plant; that while the problem of the returning veteran is in the limelight, it should not force the greater problem of civilian workers from attention. He felt that in those properly selected for positions of leadership, psychiatric orientation and training can not only recognize but also can frequently correct the trouble at its source, and that if necessary, the physician and psychiatrist may be consulted in those cases which do not react favorably to their suggestions. He felt definitely that a psychiatrist should be on the consulting staff of every modern industry. He stated that there was no cause for alarm if there was a constructive plan which included psychiatric orientation and training of the supervisory force, and the close collaboration of the plant physician and consulting psychiatrist.

Carl Schedler, director of industrial relations, The Torrington Company, spoke on "Management's Views Concerning the Employment of Physically and Mentally Handicapped Workers." Mr. Schedler pointed out that experience has shown that there is scarcely a worker irrespective of his disability that can not finally be classified as employable in some way, that frequently it had been found that if the impaired worker were properly placed, he was more efficient, less accident prone, and lost less time than the normal worker, that if the handicapped worker is placed in the proper job, to all intents and purposes he is a normal worker for that job. In respect to the returning veterans, he suggested that too much responsibility not be put upon them at first, but that this be a very gradual process as they get more and more used to their work. It may be even a year or two before a returning soldier completely recovers from what he has gone through. He felt

definitely that the medical profession would play an important part in helping to guide management in the employment of mentally and physically handicapped workers.

At the second panel in the afternoon on the subject of "Rehabilitation of the Industrial Worker," Edward Chester, supervisor of vocational rehabilitation, Connecticut State Department of Education, spoke on the "Connecticut Vocational Rehabilitation Service." Mr. Chester stressed that the ultimate aim of any rehabilitation program is safe and suitable employment for the handicapped worker. The objective is work, and the acceptance of the responsibilities of society through contribution as self supporting citizens rather than a continued acceptance of benefits of society as dependents. He outlined the Connecticut Rehabilitation Program discussing eligibility for its benefits, and the various factors in its application.

Stanwood L. Hanson, assistant vice-president of the Liberty Mutual Insurance Company, Boston, discussed "Rehabilitation Services Rendered By Insurance Carriers and Industries." Mr. Hanson stated that of course industrial concerns and insurance companies are interested in the early restoration and return to work of employees, that new interest in methods by which this may be accomplished has developed because of lack of manpower, and that every method that could be used should be utilized to this end. In his investigations he found that, though good hospital and surgical treatment had been provided, there seemed to him to be a "missing link," as he called it, between the treatment and final convalescence. In his experience, attention to physical restoration through exercises beginning even in bed, and then in gymnasiums and sports as carried out among the injured in the Royal Air Force seemed a logical approach to the problem. After consideration of the problem, the insurance company decided to open facilities for medical practitioners providing necessary baths, physical, occupational and recreational therapy for those who needed it. He felt that the application of these facilities as soon as possible after hospital and surgical treatment would permit would be a large factor in returning injured workers to their tasks more promptly and with very much less physical and mental impairment.

The last panel "Safeguarding the Industrial Worker" was started by H. William Heinrich of the Travelers Insurance Company who discussed "Safety Problems Presented by the Disabled Worker." Mr. Heinrich stated that the greatest need to our veterans is action that results in gainful employment. He stressed the necessity of providing proper transportation to and from the plant for those who had disabilities that would render special service necessary, and also, very important, transportation within the plant to and from their place of work. He felt that after all the work had been done to rehabilitate the worker and he was finally placed in the job for which he was thought fitted, one very necessary factor was that he have specific training on that job by the supervisor. He suggested it might even be well for the supervisor to try out the job under the same physical handicaps as the worker. He mentioned that special attention should be paid to abnormal hazards that may be in a job due to the disablement of the worker, and he believes that the continuous employment of these disabled men lies in the hands of the supervisors and that they should be trained to supervise this type of work. Under the heading of "Supervisor's Duties" he mentioned: (1) Engineering Revision; (2) Persuasion and Appeal; (3) Medical Control; and (4) Discipline. He stated that disabled workers make safe workers when consideration is given to placement and due consideration of special circumstances. He felt very definitely that the supervisor is the key person in fitting the individual to the job and the one to whom we must look if continuous employment of these disabled men is to be effected.

Allan Coleman, chief industrial hygienist, Bureau of Industrial Hygiene, Connecticut State Department of Health, spoke on this panel on the "Control of Environmental Hazards." He discussed the methods by which industry may be surveyed to determine what health hazards exist and the necessity of special studies wherever necessary to determine the extent to which individuals are exposed to these hazards. He briefly outlined some of the health hazards that are common to certain processes in industry and the controls that must be instituted for their elimination.

Attendance was well over 300. The day was climaxed by a dinner served to a capacity crowd. In the absence of Governor Baldwin, Dr. Barker served as toastmaster with his usual versatility and aplomb. Speeches by Alfred C. Fuller of the Association of Connecticut Manufacturers and Lt. Col. Raymond Hussey, MC–AUS, gave an impressive summation of a day which showed clearly that in Connecticut

at least, medicine and industry are marching arm in arm to accept all challenges of the future. Each speaker, or discussant, displayed a seriousness and determination which proves beyond possibility of doubt that the problems, some of them now ominous in aspect, will be capably dealt with as they arise.

## New Labelling Regulations For Drugs

New labelling regulations adopted by the Federal Food and Drug Administration have been announced. These provide that all drugs and devices which can be safely and efficaciously used by the consumer must carry adequate dosage directions. Exemptions are limited to the following classes:

1. Those drugs and devices which because of their inherent toxicity or because of the degree of skill required in their use cannot be safely and efficaciously used by the ordinary individual.

2. Official drugs which are ordinarily dispensed only after pharmacists have compounded them with other substances in filling physician's prescriptions.

3. Inactive ingredients of drugs such as solvents, colorings and flavorings.

4. Drugs and devices shipped to physicians, dentists, and veterinarians for use in their professional practice.

5. Drugs and devices intended for use exclusively in the manufacture of other drugs and devices.

6. Common household preparations, adequate directions for the use of which are known to the ordinary individual.

The amendments to the regulations under the new drug section become effective at once. Those relating to directions for use will require changes in many labels now in use and their effective date is postponed until October 10, 1945.

## 1945 March of Dimes

Last year more than 50,000,000 Americans joined one of the world's largest fraternal organizations, The National Foundation for Infantile Paralysis, by contributing their dimes and dollars to the March of Dimes. The power of their combined "dues," contributed voluntarily each year, is now giving infantile paralysis victims all over the country the best care that medical science offers today.

Last year thousands of names were added to the long polio casualty list. Epidemic proportions were reached in New York, North Carolina and Kentucky. Tennessee, Virginia, Maryland, Pennsylvania, Ohio, Michigan, Indiana, Louisiana, Mississippi, Illinois, Connecticut, New Jersey, and the District of Columbia were hard hit. In these stricken areas, representatives of the National Foundation worked unceasingly with the state and local authorities to provide emergency aid, professional workers, supplies and equipment. In this direct way were "benefits" returned to the members, the American people, who founded and maintain the National Foundation through their contributions to the Annual Fund Raising Appeals, points out Basil O'Connor, president of the National Foundation.

Funds raised through the 1945 March of Dimes, January 14-31, will be used to provide continued treatment for 1944 victims of polio and victims of previous years. They will also serve as a bulwark of defense against any 1945 invasion of this home front enemy. Fifty per cent of each contribution is retained in the county where it was provided; the other 50 per cent will be working to further the National Foundation's program of research, epidemic aid and education. Keep America strong—send your dimes and dollars to The White House.

## New Haven Curative Workshop

Additions to the Board of Directors and appointment of committee to forward the community service of the New Haven Curative Workshop were announced recently by Edward J. Brennan, chairman. Reappointment of the medical committee comprising Doctors J. I. Linde, chairman, M. S. Eveleth, C. F. Batelli and P. W. Vestal was made.

## Errata

On page 695 of the October issue of the JOURNAL, the editorial entitled The National Health should be corrected as follows:

Paragraph 2, line 5, "only 8 per cent of the total examined" to read "only 0.8 per cent of the total examined."

Paragraph 4, line 1, "the cause of rejection in 71.1 per cent" to read "the cause of rejection in 7.11 per cent."

### UPJOHN COMPANY HONORED

One of the JOURNAL advertisers, The Upjohn Company of Kalamazoo, Michigan, announce the receipt of the Army-Navy Production Award for excellence in the manufacture of materials for our armed forces.

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

*President,* Mrs. H. Bertram Lambert, Bridgeport
*Vice President,* Mrs. Creighton Barker, New Haven
*Secretary,* Mrs. Charles W. Goff, West Hartford
*Treasurer,* Mrs. Julian G. Ely, Lyme

### Christmas Letters

The first project of the Woman's Auxiliary was compiling and distributing a Christmas News Letter to all members of the Connecticut State Medical Society in military service, both in this country and overseas. A total of 600 letters was mailed in early December.

### Organization of Counties

The first county to organize was Hartford. The meeting was held on November 15, at the Hunt Memorial Building. D. Y. C. Moore, president of the Hartford County Medical Association, addressed the meeting. Mrs. H. Bertram Lambert, president of the State Woman's Auxiliary and Mrs. Creighton Barker, vice-president in charge of organization, spoke on the aims and purposes of the Auxiliary and outlined what has been done since the Auxiliary was formed in May of this year. The nominating committee presented the following slate of officers, which was unanimously accepted:

President: Mrs. Arthur B. Landry of Hartford.

Vice-president: Mrs. Ralph A. Richardson of Bristol.

Secretary: Mrs. John N. Gallivan of East Hartford.

Treasurer: Mrs. James E. Stretch of Simsbury.

Ninety-seven members and 7 guest members from other counties attended the meeting.

The organizational meeting of New London county took place on December 4 at the Pond House of the Lawrence Memorial Hospital in New London. Mrs. Alfred Labensky, temporary organization chairman conducted the meeting. Speakers were: Albert Quintiliani, president of the New London County Medical Association, Mrs. H. Bertram Lambert, president of the State Auxiliary and Mrs. Creighton Barker, vice-president.

Dr. Quitiliani welcomed the members and spoke on problems confronting both the professional and laymen in which the Auxiliary can be of great assistance.

The following officers were elected:

President: Mrs. Alfred Labensky of New London.

Vice-president: Mrs. Clarence Thompson of Norwich.

Secretary: Mrs. Frederick Hartman of New London.

Treasurer: Mrs. Edmund L. Douglass of Groton.

Tea was served by Mrs. Harold Wellington and her committee. Thirty members attended the meeting.

Mrs. Charles W. Goff, *Secretary*

### Waxed Paper from Cigarette Cartons Used As Surgical Dressing

Captain Richard A. Twyman, MC, has discovered that waxed paper from the wrappers of cigarette cartons can be used to facilitate removal of surgical dressings when the usual nonadherent substances are unavailable. Holes are punched at quarter inch intervals to permit drainage and irrigation. The waxed papers are washed with soap and water, placed in a shallow pan, wrapped like other surgical dressings and then sterilized in the usual manner.

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# SPECIAL NOTICES

## $34,000 IN WAR BONDS AS PRIZES

For the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace).

This prize contest is open to any physician member of the American Physicians Art Association, including medical officers in the armed forces of the United States and Canada.

Full information available on request of the sponsor, Mead Johnson & Co., Evansville, Ind., U. S. A.

## PAMPHLET ON SIMPLIFIED SPANISH AVAILABLE

The Pan American Society of South America has prepared a free pamphlet which gives the simple rule for changing the endings of thousands of English words, automatically converting them to Spanish words of similar meaning. This pamphlet makes possible with a minimum of study and effort a rather extensive smattering of the Spanish language and is being distributed in order to establish a wider knowledge of Spanish in North America.

Applicants for the pamphlet on Simplified Spanish should write to Pan American Society, Box 315, Quito, Ecuador, South America. The pamphlet is free.

## THE CHICAGO MEDICAL SOCIETY SECOND ANNUAL CLINICAL CONFERENCE

### Three Intensive Postgraduate Days In a Great Medical Center

The Chicago Medical Society is holding its Second Annual Clinical Conference at the Palmer House, Chicago, on February 27-28 and March 1, 1945. The sponsoring of this annual clinical conference for physicians of the Middle West has become an important function of the Chicago Medical Society following its inauguration last spring. The program presented at the first conference, last spring, was enthusiastically received by the several thousand physicians who attended. The Committee is already under way in securing speakers on important subjects for the 1945 conference. Exhibits, both technical and scientific, will be greatly increased.

## UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in Urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the Secretary for full particulars.

The selected essay (or essays) will appear on the program of the forthcoming June meeting of the American Urological Association.

Essays must be in the hands of the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before March 15, 1945.

## PRIZE FOR PAPER ON GLAUCOMA

A prize of $500 for the most valuable original paper adding to existing knowledge about the diagnosis of early glaucoma or the medical treatment of non congestive glaucoma is being offered by the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y. This award will take the place of two separate prizes of $250 each which had been announced some time ago.

Papers may be presented by any practicing ophthalmologist of the Western Hemisphere and may be written in English, French, German, Italian, Spanish or Portuguese. Those written in any of the last four languages should be accompanied by a summary in English.

The award will be made by the Society with the guidance of an ophthalmological committee composed of Doctors John N. Evans, Frank C. Keil, Daniel B. Kirby, Arnold Knapp, John M. McLean, R. Townley Paton, Algernon B. Reese, Bernard Samuels, Kaufman Schlivek, Mark J. Schoenberg, Manuel Uribe Troncoso, David H. Webster.

## AMERICAN COLLEGE OF SURGEONS ANNOUNCES 1944 APPROVED LIST OF HOSPITALS

The American College of Surgeons announces that 3,152 hospitals in the United States and Canada are included in the 1944 Approved List. The list is published in the annual Approval Number of the College Bulletin issued December 31.

A total of 3,911 hospitals were included in the 1944 survey and the approved hospitals represent 80.6 per cent. The first annual survey in 1918 included 692 hospitals of 100 beds or over of which only 89 or 12.8 per cent merited approval. Hospitals of 25 beds and over are covered in the current surveys.

A total of 2,342 hospitals of 100 beds and over were on the 1944 survey list, and 2,182 or 93.1 per cent were approved. A total of 1,119 hospitals of 50 to 99 bed capacity were under survey of which 789 or 70.3 per cent were approved. A total of 450 hospitals of 25 to 49 bed capacity were under survey of which 181 or 40.2 per cent were approved.

On December 31 of each year the ratings of hospitals under survey by the American College of Surgeons automatically terminate. The status of every hospital based upon

all data collected from the current survey is reconsidered each year.

## PHYSICAL MEDICINE RESEARCH AT HARVARD MEDICAL SCHOOL

The Administrative Board of the Baruch Committee on Physical Medicine has announced the granting of an additional total sum of $185,000, which is being given by Mr. Bernard M. Baruch for the further advancement of the program in physical medicine and the physical rehabilitation of those disabled in the war. This sum has been divided into seven grants as follows: $50,000 to the Massachusetts Institute of Technology, Cambridge, Massachusetts; $40,000 to the Medical School of the University of Minnesota, Minneapolis, Minnesota; $30,000 to the Medical School of Harvard University, Boston, Massachusetts; $30,000 to the Medical School of the University of Southern California, Los Angeles, California; $15,000 to the Medical School of the University of Iowa, Iowa City, Iowa; $15,000 to the Medical School of the University of Illinois, Chicago, Illinois; $5,000 to Marquette University Medical School, Milwaukee, Wisconsin.

The sum of $30,000 was granted to Harvard University Medical School for establishment of a three-year program to provide fellowship or residencies to be used for the benefit of qualified physicians who are selected to be trained in this field. This sum will be administered by a strong standing committee on physical medicine recently appointed by Dean C. Sidney Burwell of the Harvard Medical School, composed of Doctors J. B. Ayer, D. Denny-Brown, W. T. Green, J. H. Means, A. L. Watkins and E. M. Landis (Chairman). Appointments to the fellowships, which generally carry stipends of $2,500, will be made annually but may be renewed to provide up to three years of specialized study and research. Emphasis will be placed upon training a few men in basic research and clinical investigation.

Unusual opportunities for clinical experience and research in the psychologic and psychiatric aspects of physical medicine will be available at Harvard. The first year will be wholly or in part devoted to basic research related to physical medicine in one of the pre-clinical sciences such as physiology, anatomy or biophysics. The second year will be spent in clinical training in physical medicine at the Massachusetts General Hospital and other hospitals affiliated with the Harvard Medical School. In the third year, fellows will be assistants in physical medicine with clinical responsibilities. For candidates with extensive previous training, one-year clinical fellowships will also be granted. Applicants must have an M.D. degree from an approved medical school and a minimum of one year of internship in an approved hospital. Applications may be obtained from the Dean, Harvard Medical School, 25 Shattuck Street, Boston 15, Massachusetts.

## SEVENTH ANNUAL FORUM ON ALLERGY

The Seventh Annual Forum on Allergy will be held in the Hotel William Penn, Pittsburgh, Pa., on Saturday and Sunday, January 20-21, 1945. This is a meeting to which all reputable physicians are most welcome, and where they are offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine by two days of intensive postgraduate instruction. For instance, the twelve study groups, any two of which are open to him, are so divided that those dealing with ophthalmology and otolaryngology, pediatrics, internal medicine, dermatology and allergy run consecutively. In addition, the study groups are arranged on the basis of previous registration. In this way, as soon as the registrations are completed, the registrant is expected to write the group leader and tell him just what questions he wants brought up in the discussion. Attention is also called to the fact that during these two days almost every type of instructional method is employed. Special lectures by outstanding authorities, study groups, pictures, demonstrations, symposia and panel discussions.

On Friday evening preceding the Forum, the American Association of Allergists for Mycological Investigation will hold its annual meeting at which time the results of their cooperative research on the allergy to fungi will be reviewed. All reputable physicians and scientists are invited to attend this interesting summarization of a year of brilliant cooperative research.

Although the program is most intensive, informality and an emphasis on the practical marks the conduct of the whole meeting. Good fellowship at luncheon, dinner and smoker reigns throughout the two days, Last year the tradition was established of dining together throughout the meeting, thus offering an exceptionally fine opportunity to meet and come to know many distinguished authorities in this new and rapidly advancing field of medicine.

This year the Marcelle prize has been established through the generosity of the Marcelle Cosmetics, Inc., and will be given to the author of the best papers on allergy appearing in the American medical literature during the year. The first prize will be three hundred and fifty dollars and the second prize one hundred and fifty dollars. The awards will be based on the decision of a jury of distinguished allergists.

For further information, copies of the book and registration, write Jonathan Forman, M.D., Director, 956 Bryden Road, Columbus 5, Ohio.

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# OBITUARIES

## Daniel J. Maloney, M.D.
## 1866 - 1944

Daniel J. Maloney was born in New Britain, Connecticut July 23, 1866, where he attended both public and parochial schools in his preliminary education. In 1885 he came to Waterbury and became associated with his brothers, C. and M. J. Maloney in the publishing of the *Waterbury Democrat*. After seven years he severed his connections with the paper to take up the study of medicine at the University of New York and, after four years, graduated with the degree of M.D. on May 5, 1896. After this he spent six months in the Gouverner Hospital in New York, and in 1897 began practicing general medicine and surgery in Waterbury. In the winter of 1903-4, he did some postgraduate work in the Manhattan Eye & Ear Hospital of New York, and from then on confined himself exclusively to the treatment of eye diseases, excepting for a short time in about 1920 when he also did some throat and ear work.

Dr. Maloney was a member of the staff in both Waterbury and St. Mary's Hospitals. He enjoyed quite an active practice. He had many staunch and admiring followers and retained a number of his factory connections practically to the time of his death.

In 1902 he married Miss Edith Quigley of Litchfield, Connecticut, and they became the parents of four children, three of whom, Augustin, Emily and Benedict, were living until quite recently. Benedict enlisted in the Nation's Air Service and was killed in a plane crash. The loss of this son was a cruel blow to the doctor and was one that weighed heavily upon him up to his death.

The doctor was in many respects an unusual but likeable character. He lead a rather quiet and secluded life in a quiet, dignified way. He was decidedly a family man and had very few companions or cronies besides the family. He read extensively and enjoyed most history and the classics. He was possessed of considerable artistic ability and, aside from painting for his own pleasure, had a hobby of collecting prints, especially those of Currier and Ives of which he had a very fine and valuable collection. His other hobby was baseball of which he retained an amazing memory. He could discuss the merits and abilities of famous clubs and players of old and compare them with modern players with astounding intimacy. Discussions of history and the classics also always elicited an animation that appeared characteristically unusual in him.

He was a man of strong convictions and abided by them with no apparent thought of the consequences. He brooked no restraints in his opposition to what he considered wrong, and with equal ardor upheld what he considered right. In his relations with his fellow practitioners he meticulously conformed to all the demands of ethics. None of his associates ever had cause for resentment. He was a man of retiring habits and moderate in all things. One of his rather amusing traits was his punctuality. The neighbors all insisted they could tell the time of the day by the doctor's coming and going. After the loss of his son, Benedict, he appeared to lose interest in his affairs. He closed his office on North Main Street and carried on his work at home in an indifferent spirit. His health gradually failed and he died on August 4, 1944.

In a few more years Dr. Maloney would have been one of our associates over a period of fifty years. His seclusiveness and unobtrusive manner combined with the fact that he had gradually reduced his practice will leave many of our younger members unaware and unimpressed by his departing, but our older members who have memories of his kindliness and friendliness always will be conscious of suffering an irreparable and keenly felt loss.

T. F. Bevans, M.D..
M. H. Merriman, M.D.

## William A. Bryan, M.D.
## 1883 - 1944

With the death of Dr. William Alvin Bryan on November 7, 1944, the field of psychiatry was deprived of one of its outstanding pioneers in mental hospital administration.

Dr. Bryan was born in Creston, Iowa, on November 21, 1883. He received his M.D. degree at George Washington University in 1908, served as intern in

the United States Public Health Service in Chelsea, Massachusetts from 1909 to 1910, and then became asssitant physician at the Clarinda (Iowa) State Hospital from 1910 to 1912, the Cherokee (Iowa) State Hospital from 1912 to 1916, and the Boston (Massachusetts) Psychopathic Hospital from 1916 to 1917. From 1917 to 1920 he was assistant superintendent of the Danvers (Massachusetts) Hospital and from 1920 to 1921 assistant to the Commissioner of the Department of Mental Diseases in Massachusetts. Most of his professional life (1921 to 1940) was spent as superintendent of the Worcester (Massachusetts) State Hospital. From May, 1940 until the time of his death he was superintendent of the Norwich (Connecticut) State Hospital.

From 1933 to 1937 he was lecturer in social administration at Boston University, and in 1942 he was appointed lecturer in psychiatry and mental hygiene with the rank of clinical professor at the Yale University School of Medicine.

The psychiatric point of view which Dr. Bryan advanced throughout all the years of his career as an administrator is summarized in this statement from his book, *Administrative Psychiatry*, published in 1936: "To one who has spent a considerable number of years guiding the organization of a mental hospital through the changes that have come in our economic and political life, it becomes increasingly evident that the future of psychiatry and its influence on public health will be built around the hospital." This philosophy gave substance to the many plans with which he was always engaged. He always had his eyes on the future and was frequently criticised for being a visionary. These criticisms usually melted away with the realization of projects and plans previously considered impossible. He was a man of fire. His tenacity of purpose and persistence in fighting for his ideas found concrete expression in the establishment of the Schizophrenia Research Unit at the Worcester State Hospital and in the establishment of an extensive teaching program at both Worcester and Norwich.

Once convinced of the worth of his ideas, he did not fail to recognize the need of assistance, for which he asked without embarrassment. Having picked the men and women to assist in his programs, he defended them loyally and asked only that they do the work of which he knew them to be capable. Always open to new ideas, he often expressed the opinion that there was plenty of room in psychiatry for everyone who had anything to offer, and that as far as he was concerned he welcomed anyone who had an idea. His was a curious mixture of patience in working toward the materialization of a far distant goal and impatience to carry out as soon as possible an idea which he felt was good. Remonstrances that conditions were not yet ripe for a particular program were almost invariably met with the retort, "The idea should be put into effect and the conditions will ripen of themselves." He was not without insight into his own personality and often referred to what he called his "impulsiveness," which his associates recognized as intolerance of the lazy, the unimaginative and the incompetent. His high distinction as an administrator is in part due to the fact that he demanded the best efforts of everyone who worked for him.

His personal courage, especially in the last year of his life—when lesser men would have succumbed to the harassing exigencies of war time conditions and failing health—is an inspiration to those of us who knew him.

Often criticised for "over publicity," he answered this briefly in his book: "Hospitals that are handicapped by the interference of politics and politicians can best meet and correct this situation by a program of ethical publicity. The politician uses this weapon himself and well understands the power of it. It would be a bold man who would dare attack the institution in which the people had confidence. He would cease attempting to trade on the illnesses of human beings for his own person aggrandizement if the hospital would set out systematically to educate the people as to its needs."

He was ever seeking young men, being keenly aware of the obvious truth that the future is in their hands. He did not ask the impossible of them, only demanded their constant efforts towards the actualization of their abilities. He felt that a man who was worth his salt was of no particular value to his program if that man, after a few years, had not won recognition. He was proud to have his men invited to bigger and better jobs.

Most of all he was concerned with the future of psychiatry in terms of the community's attitude toward mental hospitals. He wrote: "When people understand that their relatives and friends must be cared for by experienced and well trained individuals and that the encroachment of partisan politics into hospital administration takes its toll in a lessened chance for recovery of the patient, this practice will cease. But the responsibility of educating the com-

# ANNOUNCEMENT

The conversion of the Neuro-Psychiatric Institute of the Hartford Retreat into the Institute of Living, which began on April 1, 1931, embraces, among other things, provision for the development of research and the ultimate development of an extensive program for training various types of specialists and personnel needed in psychiatry and allied fields.

The experience of the hospital world during the past several decades has amply demonstrated that the best professional care of patients is developed in institutions where research and the training of personnel are carried on, and that the best care of the sick and teaching and research go hand in hand.

This threefold function of the Institute of Living has found expression in the adoption of new by-laws that formally accept as the responsibility of its Board of Directors the development of the best in the care of the sick and, in addition, the development of research and the training of personnel in all the branches allied to the field of neurology and psychiatry insofar as the capabilities and resources of the Institute make this threefold purpose attainable.

BOSTON OFFICE—459 Marlborough Street, Boston 15, Massachusetts
NEW YORK OFFICE—610 Park Avenue, New York 21, New York

## THE INSTITUTE OF LIVING

Chartered 1822

Hartford 2, Connecticut

munity belongs to the administrator. I can visualize an enlightened state, free from the shackles of ignorance, superstition, and exploitation of the patient, bending its energies through well trained organizations to increase the discharge rate and decrease the admission rate. If and when this is accomplished, we shall find that the criterion upon which each employee is judged will be on the basis of his contribution to the recovery of the patient."

Dr. Bryan died believing in the future. He visualized and made plans for a fine new physical plant for Norwich. He was fighting to the very end to have a proper institution for the criminal insane, an institution which could really take care of the patients and safeguard the community. He was a valiant and farsighted man, and his death deprives psychiatry of a vigorous leader.

Louis H. Cohen, M.D.

## Frank Reichenbach, M.D.
### 1909 - 1944

Frank Reichenbach was born in Woodbury, Connecticut, April 30, 1909, the son of Weibert and Augusta Reichenbach. His early education was received in Woodbury where he graduated from the Woodbury High School. He then spent four years at Tufts Medical College where he received his degree in medicine in 1933.

In July, 1933, Dr. Reichenbach came to Waterbury Hospital and served one year as intern. He was appointed chief resident at the hospital in 1934. In 1935 he opened his office in Woodbury and about one year later moved to Watertown where he became associated with Edwin G. Reade. Dr. Reichenbach was a very promising young surgeon and was keenly alert to the challenge of the cancer problem. In 1938 he took a fourteen months leave of absence which he spent in postgraduate work in practical cancer therapy in the Westfield Memorial Hospital, Westfield, Massachusetts. Upon his return he took an active part in the Waterbury Hospital Tumor Clinic which he served as chairman for two years. He organized the out-patient follow-up tumor clinic at the Chase Memorial Dispensary which he conducted until he went into the Navy. He was instrumental in organizing a biopsy service in the Waterbury area which would permit and encourage all physicians to submit office-treated lesions for biopsy without charge. He gave much time to the active support of the Field Army of the local branch of the American Cancer Society. He was affiliated with the American College of Surgeons and was on the associate surgical staff at the Waterbury Hospital.

Dr. Reichenbach was a member of the Connecticut State, Litchfield County and Waterbury Medical Societies.

On April 15, 1931, he was married to Ellen Olsen of Brockton, Massachusetts. By their marriage they had two sons: Frank Martin, age ten years, and David Paul, age eight years.

He entered active service in the Navy on July 5, 1943. His first year was spent at Davisville and Newport, Rhode Island, and Lido Beach, Long Island. On July 23, 1944 he left for overseas where he was stationed in England and France until his death. He was senior surgeon to the 114th Construction Battalion. On November 6 he was killed in action somewhere in France.

Dr. Reichenbach was a diligent student and constantly sought to add to his own knowledge that which was available in the recorded experience of others. He was a man of culture, fond of the classics in music, art and literature. He was a kindly person with abundant good will and was loved by all who came in contact with him. His death comes as a shock to his many friends and patients and leaves all who knew him with a deep sense of personal loss.

Edwin Reade, M.D.
William E. Neff, M.D.
Joseph O. Collins, M.D.

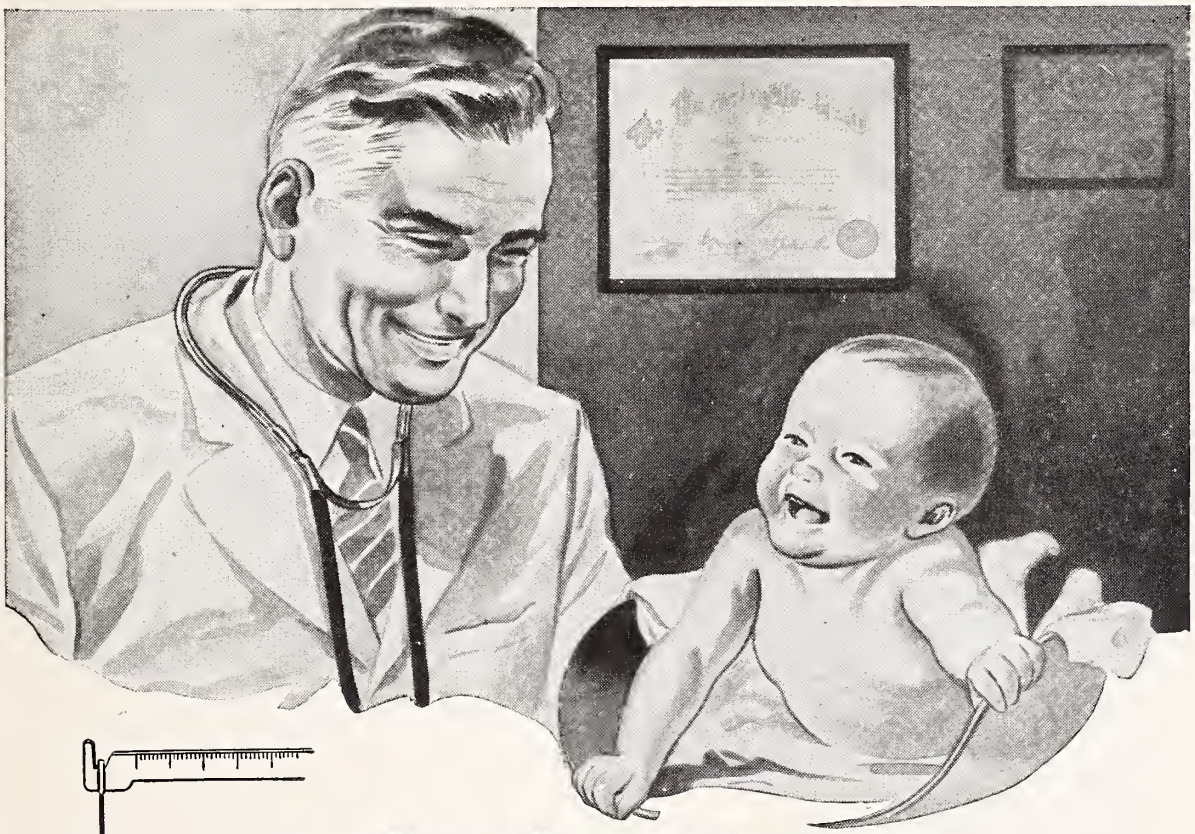
# OUR NEIGHBORS

## Massachusetts

The Massachusetts Medical Society has established a Bureau of Clinical Information at its headquarters, 8 Fenway, Boston, Massachusetts, as a means of augmenting its postgraduate educational effort.

This Bureau will supply information as to the daily activities of the approved hospitals in Boston and its immediate vicinity.

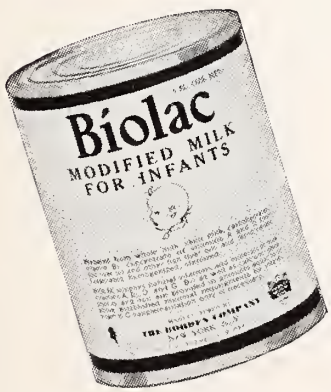
This information will deal with each hospital's schedules of operations for the day, medical and surgical ward rounds, clinics, the location of such clinics



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and the names of those presiding over these various activities.

From time to time the Bureau will make available a bulletin which will list the fixed medical meetings and conferences held in the metropolitan area. This bulletin will be sent to hospitals, medical schools, and physicians on request, and will be available at the Bureau. In brief, its ultimate aim will be to serve the profession as a clearing house for all sorts of medical information.

### New Jersey

The Medical Society of New Jersey has purchased a fifteen room house in Trenton as a permanent home. This building will house the executive and editorial offices and in addition provide six meeting rooms for groups of twenty-five and one large assembly hall with a seating capacity of one hundred and fifty. Ample parking space is available on the grounds and on adjoining streets and in the rear is a seven car garage with caretaker's apartment above. According to its *Journal*, the Medical Society of New Jersey is the oldest medical society in the United States.

The new contract of the Medical-Surgical Plan of New Jersey became effective November 1, 1944.

### New York

The Medical Society of the County of Monroe has announced plans for setting up in the near future of a non profit medical insurance plan for residents of the Rochester area. The plan to be known as the Genesee Valley Medical Care, Inc., combines features of the Michigan and Buffalo plans. It will provide for surgical and obstetrical care at the outset, later extending its benefits if and when conditions warrant. Subscribers must carry hospital insurance and belong to an employed group.

At the annual meeting of the Medical Society of the County of Westchester held at White Plains in November 1944, Laurance D. Redway, Harvard Medical School 1916, an ophthalmologist in Ossining, was elected president for one year.

### Rhode Island

The Horace Wells Centenary Committee of the Rhode Island State Dental Society sponsored a dinner in Providence on December 11, 1944 in honor of the memory of Dr. Horace Wells. Ambrose H. Lynch of Providence delivered the address on the contribution of Dr. Wells to dental and medical science and Harry M. Seldin of New York City presented a scientific paper on anesthesia.

## NEWS
## *from County Associations*

### From the Christmas News Letter

Over the desk comes the Christmas News Letter which was sent by the newly formed Woman's Auxiliary to our members in the armed forces. It is a well written newsy little folder, and one which we hope will be repeated from time to time. From it we learn news about some of our colleagues which should be interesting to our readers. Among items we note that Capt. Francis Gallo of Winsted is returned home following his escape from a prison camp in Italy. Capt. Joseph Lankin of Hartford has been awarded the Purple Heart. Major L. Caldwell Heidger of Stratford is reported missing following the torpedoing of a transport in the Pacific and Capt. Sidney Vernon of Willimantic is still believed to be a prisoner of the Japanese, having been captured at Bataan in 1942. A more cheerful note is found in the announcement of the marriage of Lt. Col. Norton Canfield of New Haven to Panchita Clark of Gloucestershire, England, and the awarding of the combat star for gallantry at Bougainville to Capt. Sidney Zaur of Bridgeport. Comdr. Charles Bidgood of Hartford is in New Caledonia and Lt. Comdr. Charles Bingham, also of Hartford, is now stationed at Naval Base Hospital, Corona, California. Concerning our women physicians we learn that Lt. Christie McLeod, USNR, of Middletown, is a pathologist at the Naval Hospital, Newport, Rhode Island; Capt. Joyce Morris, New London, is at the Army Medical Museum, Washington; Capt. Jean Henderson, of Stamford, is stationed at Camp Barkeley, Texas, and Dorothea Scoville, New London, is on field duty with the U. S. Public Health Service. At a recent Inter-Allied Conference on War Medicine at the Royal Society of Medicine in London, Major Benjamin Reiter of Bridgeport spoke on "Surgical Experiences D-Day to D-plus-7." Lt. Frederick Hartman of New London is attached to the Hornet and Lt. Samuel Climo, New Haven, is on the Barnett. Lt. Col. Ralph Tovell of Hartford is attached to Headquarters of the European Theater as Consultant

# A WOMAN'S PEACE OF MIND

No one understands the complexities of a woman's mind as well as her physician. He is fully aware that the menstrual period may often initiate temporary psychosomatic difficulties, or aggravate existing emotional maladjustments.

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(1) West. J. Surg., Obst. & Gyn., 51:150, 1943; (2) Clin. Med. & Surg., 46:327, 1939; (3) Am. J. Obst. & Gyn., 46:259, 1943.

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in Anesthesia. Lt. Francis Guida, USNR, New Haven, is located at St. Thomas, Virgin Islands. Joseph Hollinshead of West Hartford and Ralph Durkee of Hartford are both assigned to duty at Manhattan Beach, New York. Comdr. James P. Moran of New London is Senior Medical Officer on the Pennsylvania. Lt. Col. Arthur Unsworth and Major Wendell C. Hall of Hartford are at Coral Gables, Florida. Col. Ashley W. Oughterson of New Haven, Lt. Comdr. Phil McLellan and Lt. Albert Peacock of Hartford, are lately reported at the Hawaiian Islands. Lt. Allan Ashcroft of Stratford is with the Third Marines in the South Pacific and Capt. Luther Strayer of Bridgeport is now in the New Hebrides. Dr. Aaron Levy of Winsted is a medical officer in the British Army and now stationed in India. Capt. Morris Pitock of Fairfield is now Flight Surgeon at Altus, Oklahoma. Lt. Comdr. Peter Cenci, Hartford, has been transferred to the Marines, and is somewhere in the Pacific. Terrence McNulty, Hartford, is a Lt., USNR, on an L.S.T. Lt. Thomas Feeney, Hartford, is assigned to the Thurston. Lt. Col. Albert Herrmann, Waterbury, has returned from a tour of duty in Alaska. Lt. Comdr. Rocco Romaniello, Hartford, is in the Aleutians and Capt. Donald Biehn, Fairfield, has been on the Alcan Highway. Lt. Justin Cashman, USNR, North Haven, is M.O., Port of Boston. It is reported that Lt. Col. Edward Ottenheimer, Willimantic, is now in New Caledonia with a headquarters assignment. In the Fiji Islands, Dr. John C. Yavis, New Haven, is in charge of the island hospital. Capt. Raymond Markle, at one time reported missing in action, is now back in this country. Capt. Alexander Mozzer, Middletown, is in New Guinea. The Silver Star for gallantry under fire has been awarded to Capt. Jack Sabloff, New London, who is stationed somewhere in France. Lt. Comdr. John C. White, New Britain, visited at home on his way from England to the West coast. Lt. Comdr. Charles Montano and Lt. Donald McCrann, USNR, both of Hartford, are in Florida. Lt. Comdr. William J. Watson, New Britain, is stationed at Cocosola, Canal Zone. Comdr. Edward Crosby, Hartford, has been transferred to New River, North Carolina. Lt. Comdr. John Winters, Lt. James Cullen, USNR, Lt. Col. Andy Andrews and Capt. John Sayers are among the Hartford medical officers now in England. Two New Britain officers, Lt. George McMahon, USNR, and Lt. Roger Scully, USNR, are in California awaiting probable assignment to duty in the Pacific. After two years in the South Pacific, Lt. Comdr. William Neff, Cheshire, has an assignment at the Navy Recruiting Station in New Haven. Col. Charles W. Comfort, New Haven, is Commanding Officer, Station Hospital, Camp Beal, California. Col. Chester Haberlin, Stratford, has returned from the Eurpeoan theater and has left the country again in command of the 191st General Hospital.

## Fairfield

The regular monthly meeting of The Bridgeport Medical Society was held at the University Club on Tuesday evening, December 5, 1944. The speakers and their subjects were: D. C. Patterson and Elwood Jones, "Treatment of Thrombophlebitis;" E. R. Roberts, "Otogenous Encephalitis;" Marcus Backer, "Patent Ductus Arteriosus Bottali with Pregnancy;" Frank Turchik, "Tumor of the Pharynx." A discussion period followed the presentation of these papers.

## Hartford

H. Weston Benjamin has completed his first year as managing director of the New Britain General Hospital, having been appointed October 25, 1943 succeeding John C. White, who entered the Navy at that time. Dr. Benjamin came to New Britain from Boston where for the past ten years he had been doing straight clinical work and administrative medicine. For seven years he was associated with the Boston Dispensary, the Pratt Diagnostic Hospital and the Boston Floating Hospital, which institutions along with Tufts Medical School make up the New England Medical Center. For several years he was physician in charge of the District Service, physician in charge of the Children's Clinic and assistant to the physician-in-chief of the Boston Floating Hospital. He was an instructor in pediatrics at Tufts Medical School during this period. He was invited to enter medical administrative work by Frank E. Wing, director of the New England Medical Center, to whom he acted as assistant for two years. This gave him a background of experience in outpatient work, the Boston Dispensary being one of the oldest outpatient clinics in the United States. In order to obtain general hospital administrative experience, Dr. Benjamin served three years as assistant superintendent at the Peter Bent Brigham Hospital which, as an apprenticeship, combined theoretical training under Dr. Norbert A. Wilhelm, with a very practical experience in the various fields of hospital work. Dr. Benjamin is a graduate of

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Rush Medical School and served 22 months internship at the Presbyterian Hospital under Ernest E. Irons and the late Arthur Dean Bevan. He is a member of the Massachusetts Medical Society and in due course of time hopes to become a member of the Connecticut State Medical Society.

Paul D. Rosahn of New Britain, technical aide to the Committee on Medical Research, Office of Scientific Research and Development is investigating the use of penicillin in syphilis. Since his indoctrination he has visited clinics and specialists in the states of New York, New Jersey, Pennsylvania, Maryland, Washington, D. C., Ohio, Michigan, and Illinois. He attended the Post War Venereal Disease Convention in St. Louis, beginning November 9. On November 13, Major Ernest B. Howard, MC, of the Office of the Surgeon General in Washington joined him and together they toured the Southwest, stopping at Dallas, Gainsville, Houston and Galveston, Texas, Tennessee and North Caroilna.

Harold Thomas, Harvard Medical School 1915, formerly an intern at the Hartford Hospital, was one of the guest speakers at a recent meeting of the New York Roentgen Society. Dr. Thomas, formerly surgeon in charge of the Baptist Mission Hospital at Ningpo, China, and now a member of the roentgenological department of the Massachusetts General Hospital, related his experiences as a prisoner in a Japanese concentration camp. He returned with Mrs. Thomas on the Gripsholm a year ago.

### New Haven

William T. Salter, professor of pharmacology at Yale University School of Medicine and recently elected to membership in the New Haven County Medical Association and the Connecticut State Medical Society, is the author of "Antibiotics and Bacteriostatics in Blood and Body Fluids" published in *The New England Journal of Medicine*, November 9, 1944.

## News from Yale University School of Medicine

Francis G. Blake, John F. Fulton and Arthur Geiger participated in the program of the Yale Medical School presented on November 8. Dr. Fulton with Leslie F. Nims, PH.D., was the author of a paper on "The Importance of Carbon Dioxide in Aviation Medicine." Drs. Blake and Geiger contributed a paper on "Treatment of Subacute Bacterial Endocarditis with Penicillin."

### Standard Unit Adopted For Penicillin

The Conference for the Standardization of Penicillin recently held in London under the auspices of the Health Section of the League of Nations decided upon a pure crystalline preparation of a sodium salt of penicillin G as the International Standard, and defined the International Unit as the penicillin activity contained in 0.6 microgrammes of the International Standard.

Agreements of this kind were first reached for antitoxins, when in 1921, the Health Committee of the League took up the question of measuring the activity of a number of modern biological remedies in order to obtain international uniformity by agreements to use a common set of standards and units. Standards for vitamins, hormones, insulin, digitalis, arsphenamine (powder used for protozoan infections) were subsequently decided upon, with the result that today the activity of over thirty biological products are being assessed in terms of international standards. They are distributed throughout the world for the League by the National Institute for Medical Research, London, and the State Serum Institute, Copenhagen, even in war times.

The Penicillin Conference, to which Sir Alexander Fleming, father of the miraculous drug, came, as well as three delegates each from the United States, and Great Britain, and one each from Australia, Canada and France, also adopted a Working Standard. This Working Standard, for distribution to laboratory workers, consists of a calcium salt of penicillin, 2.7 microgrammes of which were accepted as containing 1 International Unit of penicillin. Both the International and the Working Standards are to be deposited with the National Institute for Medical Research in London.

### Army Reconditioning

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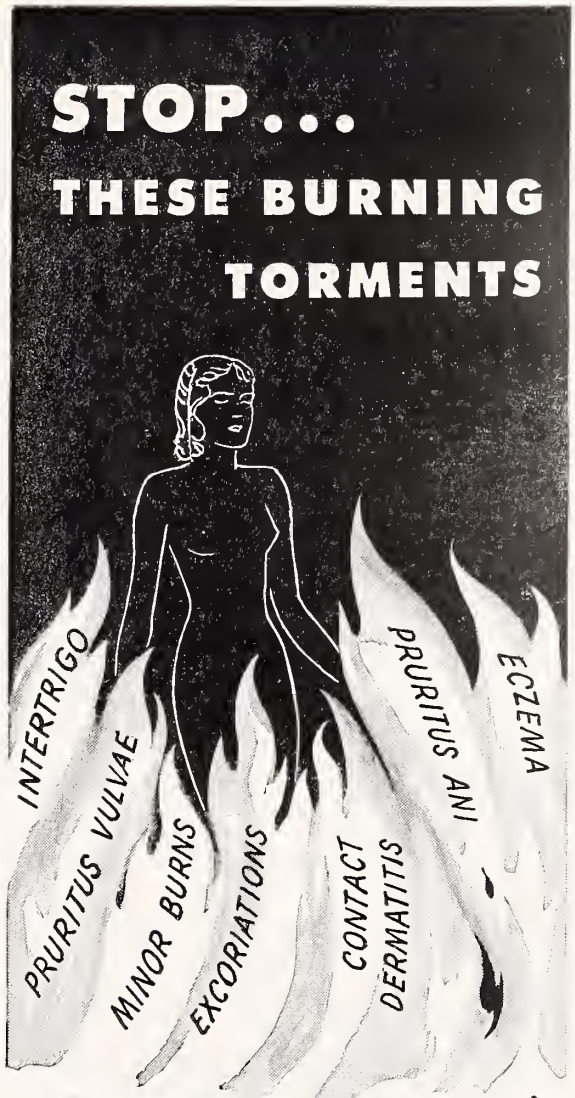
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# NEW BOOKS IN REVIEW

*MODERN CLINICAL SYPHILOLOGY.* (Third Edition.) *By John H. Stokes,* M.D., Professor of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; Director, Institute for the Control of Syphilis, University of Pennsylvania; *Herman Beerman,* M.D., SC.D. (Med.), Asst. Prof. of Dermatology and Syphilology, School of Medicine and Graduate School of Medicine, University of Pennsylvania; and *Norman R. Ingraham, Jr.,* M.D., Asst. Prof. of Dermatology and Syphilology, School of Medicine, University of Pennsylvania. *Philadelphia: W. B. Saunders Company.* 1944. Cloth. 1,332 pp. with 911 illustrations. $10.

Reviewed by F. EARLE KUNKEL

This is the most authoritative of all available books on syphilis. It has been the standard textbook of syphilis ever since the first edition appeared in 1926. It is not only an essential book for the specialist but a most necessary book for the practitioner and student.

The authors and collaborators have written "simultaneously for the student, as illustrated in the summaries and the principes; for the practitioner, as illustrated in details and cases; and for the expert, as shown by the discussions and references to the literature." They indeed have telescoped three books into one.

The greater part of the text has been rewritten. Every chapter has been thoroughly brought up to date. There are new chapters on penicillin in the treatment for syphilis, and syphilis in public health and military medicine. The chapter on congenital syphilis has been expanded and rewritten. Serological tests are more fully discussed, especially that portion devoted to the biologic false-positive reaction, an extremely important problem to the doctor and patient these days. Every important treatment regime is given full detailed and practical discussion. The authors are convinced that "old and new must mingle for another ten years before the arsenicals pass, perhaps with late and even early syphilis into limbo. The principles have a touch of the immortal, though the facts shift and change." The first textbook summation of the detoxicants and penicillin in the field of syphilotherapy is contained in the final chapter.

The chapter on current developments of penicillin contains a historical summary, the known and the unknown on penicillin in syphilis, outstanding problems in the advent of penicillin, the problem of partially completed arsenotherapy, penicillin in latency, the importance of follow-up, the treatment of early syphilis, early syphilis in pregnancy, late syphilis, congenital syphilis and neurosyphilis wi penicillin.

The authors state that "two figures were coming in being as the third revision of this textbook was approachin completion—the one destined to become a giant, the oth probably a dwarf. Intensive arsenotherapy was reaching i full stature in massive foreshortened treatment—its so remaining drawback, toxicity. The promised (though n yet completely fulfilled) answer to toxicity is the advan of knowledge of the detoxicants, which can make the arseni heavy metal combinations safe. Just as safety seemed withi reach, and arsenotherapy about to mount the giant's thron a reactionless, safe antibiotic agent, penicillin, challenged i title to the sceptor. Though the rivals will for some tim dispute the title, and the struggle perhaps end in a compr mise arseno-penicillin handclasp, it is already growing clear which will be the ruling giant, which the subordinated not defeated dwarf. Even the drama of the occasion doe not, however, justify as yet calling the giant Penicillin th King. But at least we know that we can now cry, "the kin is dead—long live the King;" and with this introduction, i will soon be possible for the reader to infer by space an type font, which way our personal beliefs on kingship ar tending. His first problem then, is to decide how to conduc himself in the interregnum.

"For the interregnum, these reflections are suggested:

"1. The established principles regarding syphilis and it behavior under treatment have not lost their meaning Without them we might well be in a milling mob.

"2. The arsenotherapeutic era warns us against the repeti tion of the serious mistakes of 1911-1920—the one-dose cur unachieved; the infectious relapse unrecognized, follow-u unknown, titered serologic tests as measurements of treat ment response non existent, the spinal fluid warnings o asymptomatic neurosyphilis unsought for, neurorecurenc unforeseen, the variations in drug activity and behavior un suspected, treatment allergy yet to be heard of, the cause and prevention of serious reaction guessed at, overlooked slowly and painfully brought to light, with an irreducibl residue of mortality confronting us almost until today.

"3. The arsenotherapeutic era has set base lines and stand ards in curative and palliative performance in fractions of a per cent against which to measure new claims to therapeuti preeminence; has trained minds and organizations in logic teamwork, planning and procedure, and in the evaluation o chemotherapeutic agents; has been combined with collatera methods (fever therapy for example) that will now in turn be integrated with the new discovery. It may be even s combined with the new to bring, for the first time, the one hundred per cent cure.

"4. The arsenotherapeutic era has warned of the dangers of loose thinking—letting down the bars on standards, "push-

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g" a hoped for result.

"5. The arsenotherapeutic era has taught, and it has in the me process set limits on the conclusive significance of time the evaluation of results. Less than a lifetime now will ecide the new order—less than a decade, perhaps, because f what we know from the past.

"6. For years to come there will be patients who have ad the old treatment, whose decisions must be made for iem on the basis of the old, plus the new.

"It appears then, that penicillin, if and when enthroned, ill literally climb to the seat on the shoulders of the sound, stablished and effective past of syphilotherapy.

"From A. D. 1943, it will take a year to guess, two years o intimate, five years to indicate, a decade or more to know hat penicillin does in syphilis."

The publishers have contributed generously. The technic f their craft is unsurpassed. The book is attractively and ubstantially bound. This scholarly volume is undoubtedly ne of the important contributions to the medical literature nd should have a place in every physician's library.

*IANUAL OF MILITARY NEUROPSYCHIATRY. Edited by Harry C. Solomon,* M.D., Professor of Psychiatry, Harvard Medical School, Medical Director at the Boston Psychopathic Hospital; and *Paul I. Yakovlev,* M.D., Clinical Director, Walter E. Fernald State School, Instructor in Neurology at the Harvard Medical School. With the collaboration of 11 doctors. *Philadelphia and London: W. B. Saunders Company.* 1944. 764 pp. with 15 illustrations. $6.00.

Reviewed by C. C. Burlingame

A very useful compilation for the military neuropsychiatrist, indeed for any medical officer, is the present manual, produced under the editorship of Dr. Harry C. Solomon and Dr. Paul I. Yakovlev. It is actually the outgrowth of a smaller previous collection of postgraduate lectures on the neuropsychiatry of war delivered in 1941-42 at the Metropolitan State Hospital, Waltham, Mass., and serves the purpose of a reference text incorporating the lessons and leads obtained from three years' participation in global conflict.

The topics covered range from the role and organization of neuropsychiatry in the Army to the prophylactic and therapeutic aspects of the subject. Included are sections relating to induction psychiatry, to administration, and to disposition of the neuropsychiatric problems encountered in the various branches of the armed forces. Clinical entities receive attention from many points of view, starting with psychoneurosis and psychosomatic disorders, and proceeding through psychopathic personalities, alcoholism, sexual deviates, malingering, mental deficiency, epilepsy, the principal psychoses, and diseases and injuries of the nervous system. Such special topics as tropical neuropsychiatry, convoy and torpedo casualties, and the physiology of flying, treated in a final, miscellaneous section, offer additional testimony of the need on the part of today's medical officer for a comprehensive background in the specialty.

The authors of the various chapters are preeminent men in their field, and lend authority to a volume which can be highly recommended to the medical profession because of its interest, utility and reference value.


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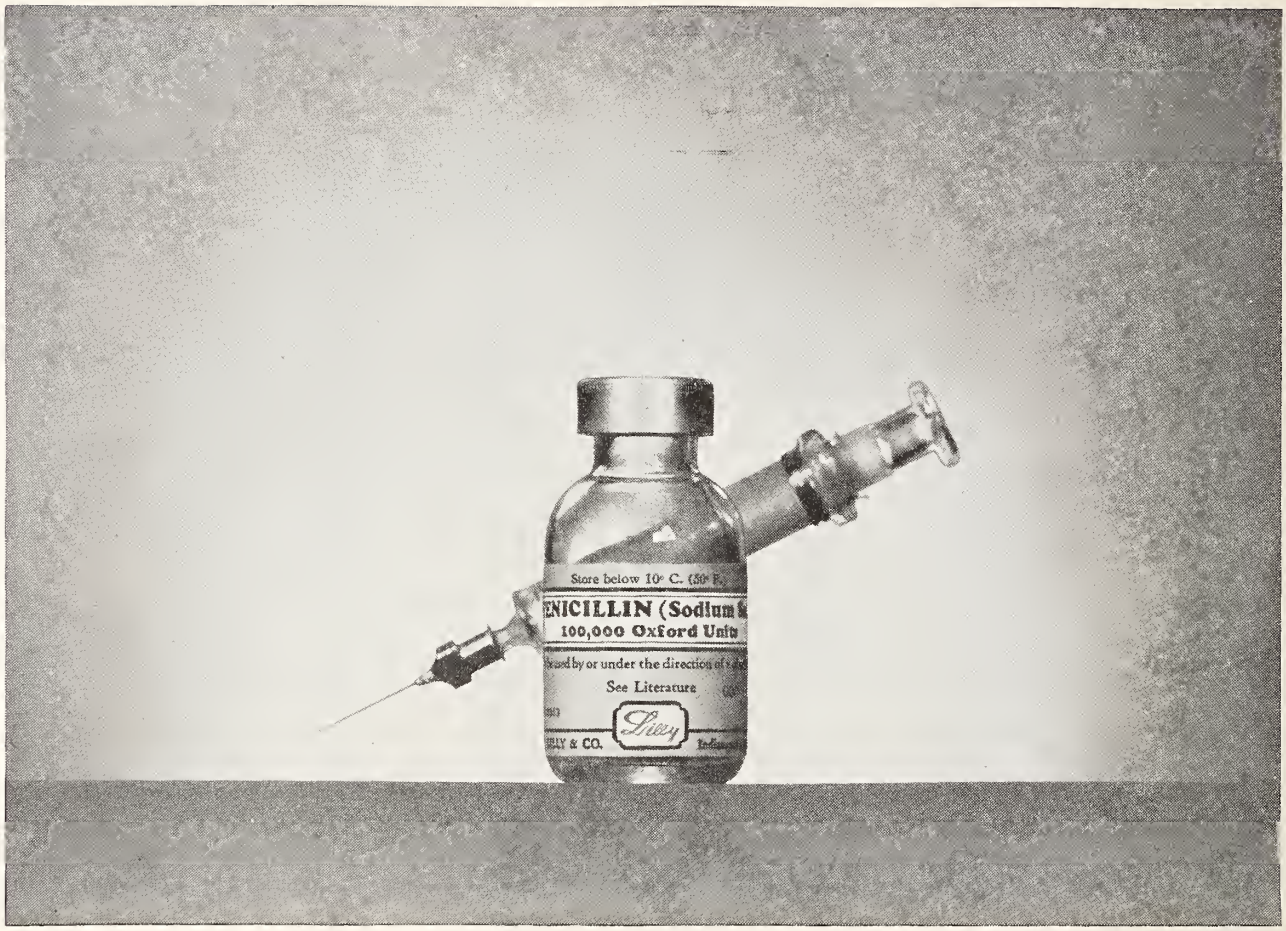
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# INDUSTRIAL MEDICINE AND THE GENERAL PRACTITIONER

C. F. YEAGER, M.D., *Bridgeport*

The Author. *Medical Director Remington Arms Co., Chairman, Committee on Industrial Health, Connecticut State Medical Society*

THE DEVELOPMENT and expansion of medicine in industry during the past several years has been so great that industry itself is somewhat bewildered. We can hardly expect the general practitioner, therefore, to be fully conversant with the present day scope of industrial medical practice. In this paper, I will attempt to show how the general practitioner fits into the new era of industrial medicine. In order to do this I must first explain some of the reasons why industry has gone into medicine. I might say that I will explore for you this business of "doctoring in industry;" and for this purpose I will divide the development of industrial medicine into three eras.

The first era began with the adoption of workmen's compensation laws which, as you know, made it mandatory on the part of industry to carry insurance which would pay the expenses in connection with the treatment of occupational injuries (and in some states, occupational diseases) and to compensate the injured for loss in wages. This placed quite a financial burden on industry. Since the individuals who own and manage industry are fundamentally business men, they immediately set about to find ways and means of reducing their compensation insurance costs. In order to do this, two things were necessary: (1) to provide immediate first-aid to the injured; (2) to prevent accidents.

The first objective was accomplished by providing first-aid or dispensary facilities in plants, supervised by a trained person in first-aid or a nurse. This service was supplemented by having a physician, or panel of physicians on call. Needless to say, these original industrial physicians were, for the most part, surgeons. In industries where this type of medical service was instituted, compensation and medical costs dropped immediately. Such a saving to industry could be readily calculated. It was a *direct* saving.

During this era also, accident prevention began to receive serious attention. Industry began to safeguard machines, exhaust and ventilate operations which were known to cause injuries to health, employ safety experts, and teach employes how to work safely. Although there is a great deal yet to be done in preventing accidents, industry, in general, has made tremendous strides in this direction, and deserves a lot of credit. Perhaps you will permit me to give a rather interesting example from my own company of results achieved by persistent safety efforts; the employes of one Remington Arms plant take much pride in the fact that the plant has not had a single lost-time accident since March, 1934—more than ten and a half years ago! Other companies could add many striking illustrations of encouraging progress. It is safe to say that today the total amount of major industrial surgery necessary in the average industrial town of a population of 150,000, could easily be done by one surgeon.

During this same era, industry also found that pre-employment physical examinations, to determine the physical ability of an employe to do the job for which he was being considered, were advantageous from a direct cost standpoint. This was done by many more companies than you perhaps realize.

*Presented at the Queens County Medical Society, Forest Hills, N. Y., October 30, 1944*

The second era in industrial medicine began when the economists in industry found that their *indirect*, or hidden, costs could be reduced by employing a full or part-time physician. They found that, whereas, they had 100 machines to accommodate 100 employes, they were only able to produce material from about 94 machines, for the reason that, on an average, 6 employes were away from their work continuously because of sickness or injury. On investigation they found that the total number of days lost for non-occupational injuries and illness exceeded the days lost for occupational injuries and illness by as much as 50 to 100 times. It was apparent to industry that employes who were properly placed and examined frequently would lose less time from work.

In addition, a plant physician could be of material value in creating healthy working conditions. The advantages of this service were immediately observed by both management and employees. The employe was healthier, happier and was able to earn more wages. Management had less employment turnover, increased quality and quantity in production, and improved employer-employe relations.

You are already familiar with the scope and objectives of this type of medical service. We can definitely say that present day industrial medicine is Preventive Medicine. The industrial physician is simply applying recognized public health measures, and is in reality the public health officer for industry.

This public health service, however, is for an age group which, heretofore, was sadly neglected. For example, today public health measures begin with the expectant mother, and continue after the birth of the child through pre-school, grade school, high school and college years. As private practitioners, you are all quite familiar with the recommendations made by school physicians and submitted to parents and guardians. You are also familiar with the tremendous improvement in the present day health of pupils and students. But I am sure you will agree that very few of your patients report to your office once or twice a year simply to get a physical checkup. It is precisely this important phase of public health which many industries are today promoting through their medical departments, with mutual benefit to employe, employer, and the family physician.

Frankly, I am at a loss to understand how the dentists get their patients to report regularly once or twice a year for treatment or examination for such a very small portion of the total anatomy—unless it's for reasons of vanity. Or can it be the influence of radio commercials? Perhaps we should do more advertising regarding the value of periodic physical examinations. In any event, a great many industries are examining all of their employes periodically. During the physical examination the employe is advised of any physical deficiencies and is referred to his own private physician for treatment or advice. In some plants this examination includes: complete blood counts, Wasserman tests, urinanalyses, chest x-rays and electrocardiograms.

This type of work has been done by the Remington Arms Company, in Bridgeport, Connecticut, for the past 11 years with remarkable success. At the beginning of the program the general practitioners or family physicians were a little skeptical about the plan. They soon learned, however, that we were performing a service which was not only valuable to the company but also to their patients and themselves. Within a short time many a physician began seeing some of his old patients long before they might have been expected to come to his office with subjective symptoms, as a result of the plant's periodic examinations. No one can dispute the value of this type of program as a public health measure and true Preventive Medicine.

There are, as you might expect, some misunderstandings on the part of general practitioners on occasions. Having done private practice, I have a full appreciation of some of these misunderstandings. Let me give an example:

An employe presents himself to his foreman with a note from his private physician stating that his patient cannot work on a certain shift and recommending that he be taken off his present shift immediately. The foreman, naturally, refers the employe to the Medical Department where the case is reviewed. As industrial physicians we know that with the exception of a case of arrested pulmonary tuberculosis, arthritic conditions and perhaps a few others, it makes little difference which 8 hours out of the 24 an employe works. It is true that certain shifts might be inconvenient and less desirable from the employe's standpoint. It is easy enough for him to go to this physician and say: "Doctor, the work at the plant is getting me down. I just can't work these shifts. Will you give me a note so I can get my job changed?" But in time of war, when production schedules set by the Arms Forces *must* be met, it is not possible to suit the conveniences of everybody,

despite our best efforts. If two or three shifts are necessary, isn't it reasonable and fair to ask all who can do so without real harm to share the inconveniences of night hours, as is done in our case by a system of rotating shifts?

I cite this example as one which you have all probably run across at one time or another; and doubtless you are familiar with other cases of a kindred nature. Obviously, if industry today were to carry out all the recommendations sent in by family physicians, it could hardly function. I should like to suggest, therefore, the desirability and importance of the closest cooperation between family physicians whose patients may bring these requests, and plant physicians, since this problem calls for thorough understanding on both sides and the best cooperative effort to work out a satisfactory solution in each case.

As many private physicians know from experience, the making of unwarranted requests by employes can reach proportions and extremes that prove embarrassing. In one community where the practice became vicious, the local industries approached the Medical Society for help and advice. The situation was quickly remedied when the Society appointed a committee to review all medical certificates presented by employes from their physicians.

Today, we are embarking on a new era of expansion in industrial medicine. The new laws which regulate and control employment in industry and the increasing interest on the part of labor organizations are mainly responsible for this new era. Already, smaller industries which, heretofore, did not have any medical service to speak of, are now appealing for help in the development of a medical program. Industrial physicians have attempted for many years to interest more physicians in the field of industrial medicine and various methods have been tried with very little success. Again, the cart is in front of the horse; industry has taken the initiative.

Many of the Labor Union contracts throughout the country now contain provisions for company dispensary facilities and medical services. Whereas, several years ago the Unions were skeptical about such services they have now come to realize that the employer is not the only one who benefits. In addition, the Manufacturers Associations throughout the country are realizing that a definite Rehabilitation Program is vitally important to industry's future welfare, and have indicated that the services of at least a part-time physician will be necessary for a company to carry through such a program effectively. As physicians we know that an employment manager could hardly be expected to determine what types of employment would effect Psychoneurosis or Shistosomiasis. I will not attempt to explain all of the provisions of the G. I. Bill of Rights or the Selective Training and Service Act. However, I would like to familiarize you with the purposes of the law in order that you will have some idea as to the complexity of the reemployment and rehabilitation problems.

Probably the greatest number of veterans seeking reemployment and needing rehabilitation will be those with minor injuries or loss of skill who will require only proper job placement plus reasonable on-the-job instruction, plus adequate follow-up to insure proper adjustment.

Other types of casualties will be those whom the employer cannot deal with and for which society at large, through the government, will have to accept responsibility. Another type will be handicapped individuals who will need a great amount of specific training to make them employable but who will eventually become gainfully occupied. These men probably will receive training through public facilities and the employer should constantly keep in touch with them, lend them encouragement, and try to offer employment when trained. Generally the rehabilitation program should follow the same pattern as in the war period. Close contact should be maintained with the Rehabilitation Section of the State Departments of Education, the Veterans' Administration, the Veterans' Employment Service of the USES, and the Personnel Division of Selective Service through the Reemployment Committeeman.

Mainly, the program should follow these lines:

(1) To place the individual on a job for which he is best suited and on which he can perform in a satisfactory manner after a reasonable period of breaking in;

(2) To remove from the program any taint of sympathy or charity for the individual. He must be given to understand that he is making a definite contribution to the community;

(3) To give responsibility for placement to a competent person who is thoroughly familiar with the job within the plant. In a large plant the person in charge of placement should be a thorough-going "job evaluator," with a sound knowledge of what each job requires of the operator;

(4) To check and guide placement and follow it up with adequate medical supervision.

Obviously the services of a part time physician can be utilized by the small company which is mapping out its rehabilitation program. The physician can become familiar with working conditions and occupational hazards generally. He can also deal with the individual rehabilitation case in an intelligent manner if he is well acquainted with the plant. This would require counselling with the personnel department in proper placement of the disabled veteran, follow-up and advice, if necessary. In large plants these functions will be the responsibility of the plant physician.

I think it will be obvious to you, in view of the situation confronting us, that many more physicians will be required to assist industry with this tremendous task. As I see the problem it will be necessary for American industry to depend mainly on the general practitioner to get this enormously important job done. Fortunately, many general practitioners already have close contacts with industry and so we are not starting from scratch. But we have a long way to go.

In order to meet this situation the following plan is submitted for consideration:

(1) Contact the local Manufacturers Association and through the Industrial Health Committee determine the following information:

(a) The number of industrial concerns in your vicinity and the approximate number of employes in each;

(b) If possible, what their post-war outlook is, insofar as employment is concerned;

(c) The types and extent of medical services in each.

(2) Take a census through your Medical Society to determine the names of all physicians who would be willing to assist industry.

(3) Continue to develop and expand both undergraduate and postgraduate teaching of industrial medicine and hygiene.

Finally, may I suggest that this whole problem is now rapidly building up and will be upon us in all its magnitude before long, if all goes as well overseas as we hope and believe it will. The time to plan and prepare, therefore, is now.

# NEUROPSYCHIATRY AND PLACEMENT OF INDUSTRIAL WORKERS

MATTHEW BRODY, M.D., *Brooklyn, New York*

The Author. *Consulting Neuropsychiatrist, Sperry Gyroscope Company*

THE PRESENT war situation with its all-out effort has brought the problem of psychiatric disorders to the foreground. Many have been upset by the revelation of the large numbers of emotionally handicapped individuals in the community. Employers have shared this dismay and even the misinformation that prevails about this problem. Veterans discharged for neuropsychiatric reasons in many cases have had to conceal the cause of their disability in order to secure work, because the "N.P." label carried with it an erroneous connotation of insanity to the half and misinformed. What is needed is an educational program. With the dissemination of psychiatric knowledge a more rational approach will be possible. At that time, psychiatrists will find themselves consulted at greater frequency concerning the employability of individuals. Before he can offer such advise, he must understand something of industrial procedures and problems.

Industry is run for profit. It can never be run exclusively for the purpose of occupational therapy. Loading up an organization with individuals prone to absenteeism, frequent job changes, poor work habits, querulousness, prolonged invalidism, and accidents will work a disrupting and costly influence. On the other hand, most psychoneurotics are em-

*This paper includes material presented at The Connecticut Society for Psychiatry and Neurology, September 28, 1944 and The National Committee for Mental Hygiene, November 8, 1944. It also includes portions of a paper "Dynamics of Mental Hygiene in Industry" which will appear in* Mental Hygiene, *April 1945, with the kind permission of Dr. George S. Stevenson, Medical Director of the National Committee for Mental Hygiene.*

ployable if properly placed and handled. In fact every psychiatrist knows of such individuals who are doing a fine job, and are occupying sucessfully positions of responsibility. The percentage of psychoneurotics in the community is so large that were industry to discharge everyone with such a defect it would find itself seriously handicapped. If industry should attempt too rigid a system of selection of employees, it will find that prospective workers will conceal their defects. Further every person not employed is a charge upon the community, the burden of which in large measure is borne by industry. Plant managers can be assured that the problems they will face after the war will not differ markedly from those they have handled more or less successfully in the past when these men were not labelled. However, they will be able to do a more satisfactory job of supervision when they understand these problems, and when the workers are better placed and supervised.

Before a psychiatrist can offer advice as to the employabiltiy of an individual, he should know something of industrial placement procedure. Often enough when a worker with a neuropsychiatric defect is referred to the specialist a lengthy report is returned with a well thought out diagnosis. But the poor plant manager has not the vaguest idea what to do with it, because the essential questions as to whether, where or how he can be employed are not answered.

In a small plant the question of placement, matching the applicant to the job, is simple. The proprietor knows every job, and a little about the personalities involved. It is relatively simple for him to know in advance that John Doe will fit in, and can do the job in question. When plants become larger, types of jobs more numerous and the question of interpersonal relationships more complex, then job placement becomes a more complicated procedure that is making of personnel work a profession. The problem still resolves itself to sizing up the job, sizing up the applicant and matching them.

Each job has certain requirements, or demands. These are:

1. *The physical demands of the job and its environment.*

The United States Employment Service of the War Manpower Commission has worked out a careful job analysis scheme. As jobs become more specialized, fewer physical requirements are demanded. These requirements are specifically stated. Some 20 to 30 different items are included under physical activities (as walking, balancing, sitting, handling, fingering, seeing, hearing, depth perception, etc.), and a similar number under working conditions (as inside, hot, cold, dry, noisy, dusty, hazardous, working with others, etc.). A surprising number of jobs will be found that will require but one arm, or no vision, or no hearing, etc.

2. *The intellectual demands of the job.*

It is as much a mistake to place too bright an individual as too dull a one on a job. The bright one may become bored, careless and indifferent. The excessively dull may seek any of the compromises and escapes known to psychiatry to preserve his ego rather than acknowledge his inability to do the work.

We had one veteran, a parachutist discharged for a back injury, whose mental age was 9. We recognized this and thought we had a relatively simple job for him in the packing department. Within a few days we were told that his conduct was bizarre. Upon investigation we discovered that what we had considered a simple job involved packing 25 different items in 15 different packages and the operation of a stitching machine. It was far beyond his capability. Our error here was based upon a faulty evaluation of the intellectual demands of that job.

3. *The technical demands of a job.*

The best judge of this is the supervisor who can also determine whether the applicant has the necessary experience and skill. This applies especially to the more highly skilled jobs. I would no more attempt to decide whether or not a man is a good tool and die worker than I would expect a hospital steward to choose a clinical director or a pathologist.

4. *Intangible factors.*

These include the emotional demands of a job. We confess our inability to determine all of these factors. We know of no way of doing a Rorschach on a job. We are doing the best we can. We would not hesitate to employ an effeminate individual as an illustrator or in certain clerical positions. We would refrain from putting him in the foundry. An interesting illustration is the experience of the British Army. One would suppose that a person best suited to drive a tank would be one with previous driving and mechanical experience. Yet tank drivers did poorly in tanks. The tank requires a crashing, destructive tendency which has been trained out of cab drivers. It is these intangible factors which make an ideally complete job analysis difficult.

The job analyst is responsible for compiling the job requirements for each job and the results are accessible in the employment office. What has been done for the job, must now be done with the prospective employee. The individual is studied to discover what his capacities are, and the outline follows that of the job requirements. These are:

1. *Physical Assets.*

The interviewer is furnished with a comprehensive medical diagnosis from which he determines what the applicant's physical assets are. The interviewer's attitude is a positive one. If a man is deaf, he can still walk, finger, employ a known amount of depth perception, etc. As a matter of fact he is at an advantage in a noisy environment. Likewise we have found that the blind have a compensatory increase in tactile perception which places him at an advantage in certain types of jobs where fingering is important. Using this type of approach and attitude, the placement of the physically handicapped is comparatively a simple procedure. Where difficulties are encountered, one can presume that emotional complications are interfering.

2. *Intellectual assets.*

In this part of the country where schooling is universal, the applicant's rate of progress in school is usually a sufficiently satisfactory index of his intelligence. Where required brief psychometric examinations may be performed. We believe that too great an attempt at accuracy in this regard with all employees is unnecessary and excessively expensive.

3. *Technical skills and experience.*

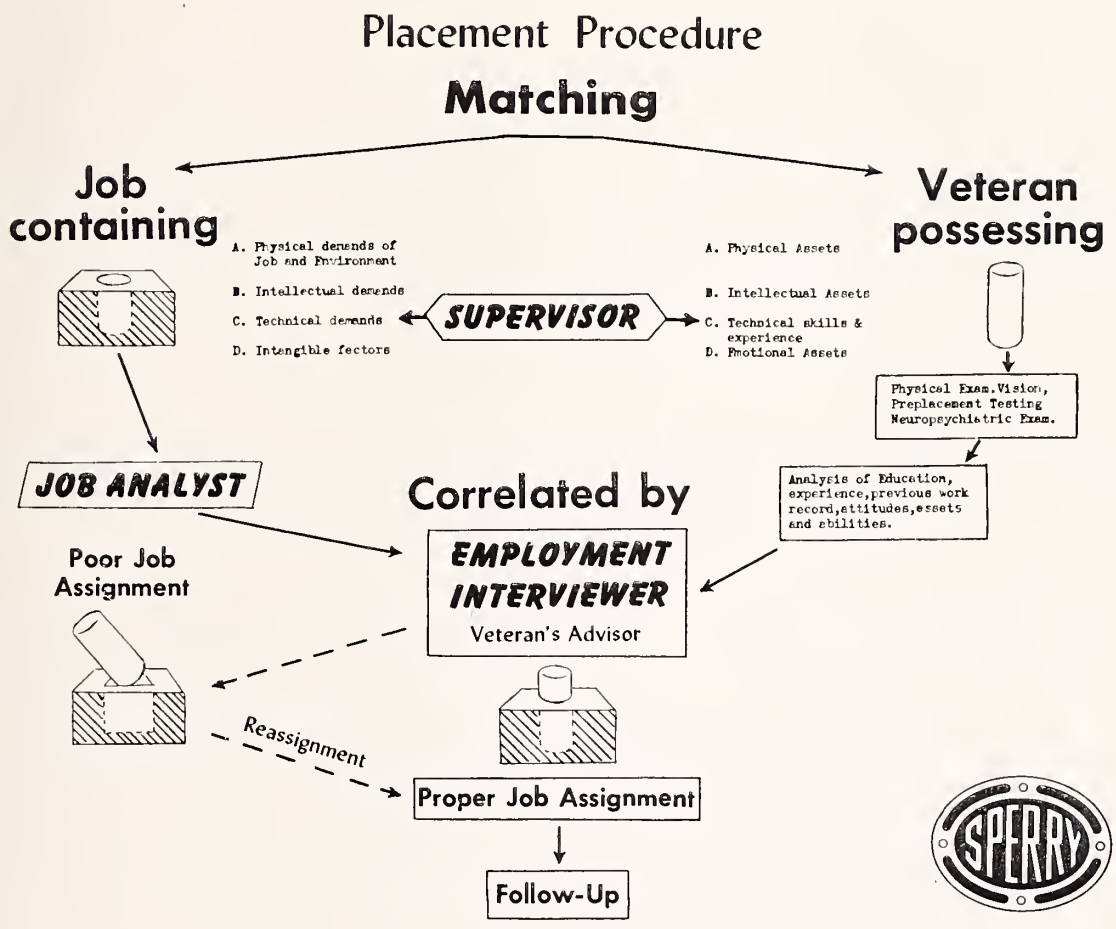
These are brought to the attention of the prospective supervisor who is the final judge.

4. *Emotional assets.*

We use this term deliberately because we have found to our dismay that psychiatric diagnoses by themselves are not the sole criteria in placement. Ordinarily one would presume that the psychotic is universally unemployable. This is not entirely true. I have in private practice a former pugilist who is punch drunk (Post-traumatic Parkinsonism). For the past 15 years he has been suffering from a Paranoid condition. He feels that a group of people pursue him in the subways and annoy him by shaking their newspapers, pointing at him and passing flatus. During this entire period of at least 15 years he has been working steadily. In the past four years he has been employed in a war plant cutting steel. I understand that his work is satisfactory.

On the other hand where a Paranoid trend involves the company, supervisors, equipment or anything connected with the work situation, it is generally impossible to employ such an individual.

I mentioned the above case deliberately, not so much to demonstrate that schizophrenics are occasionally employable, as indeed they rarely are, but to show that a psychiatric diagnosis by itself is of little use in industry. This holds true for every psychiatric classification, although with the psychoneurotics, the percentage of employables is much larger. So we have instructed our employment interviewers that they can almost disregard any history of a nervous breakdown. We have told them that as a matter of fact certain types of psychiatric liabilities such as over-conscientiousness, perfectionistic traits, etc., if properly channelized, may constitute industrial assets. We object to an exclusively cross-sectional view of an applicant and demand that he be considered from the longitudinal point of view as well. Consequently we feel that the employment interview, properly done, constitutes the best guide as to placement. We are skeptical as to the value of the "paper and pencil" personality tests, because usually they tell us nothing about the applicant's past work record. We are however experimenting with group Rorschachs, etc. The interviewer is instructed to adopt the neutral attitude and to permit the applicant to tell his own story in his own way. In evaluation, emphasis is placed upon his *previous work history*, and his previous school history. If a veteran, the army record is examined for evidence of leadership shown and special skills learned. We are interested in the attitudes he has shown to persons in authority, in the evidence of maturity and responsibility as shown by his marital status, savings, and his attempt to establish a home. If a veteran, the length of time it takes for him to apply for work is important. Generally speaking the sooner the veteran wants to work, the better his prospects. The veteran who has to rest at home for vague and indefinite reasons, is often a psychoneurotic who lacks insight. On the other hand, the veteran who states that he did not want to work earlier because his nerves were shot, but that now he feels better, at least has some insight and is making some attempt to face his difficulties. Should there be any question, the interviewer is free to request a psychiatric consultation. This serves two purposes, first, specific advice is given in the problem. Second, the discussion that follows the consultation points out the factors involved and aids the interviewer in his orientation.




When a former employee applies for reinstatement following discharge from the armed forces, the problem is much simpler. We know what he has done in the past. Also the mere fact that he is reapplying shows that he was happy in his former placement. When the previous job no longer exists, or when the physical or mental status of the veteran has changed, it is necessary to make a new placement.

When an employee is referred to me by the interviewer, veterans' counselor, supervisor, or plant physician, the reason for the referral precedes him. The employee is honestly told that they wish him to see the psychiatrist to aid in his placement, or in his adjustment to the job, or whatever the reason may be. I have found no resentment on the part of anyone referred to me. The employee is under no compulsion, and what he reveals is considered confidential except for the brief report sent. As far as employment prognosis is concerned, I rely chiefly upon the previous work record. Where a neropsychiatric condition is present, consideration is taken of the acuteness of onset, duration of illness, adequacy of treatment, presence of affective features, whether or not improvement is continuing, presence of some degree of insight, and what the motivations are that determined his return to work. The presence of antisocial trends generally preclude employment. Accident proneness is considered a bar to employment. Some psychopaths may be employed if they can be without expenditure of money for training, or if they can be placed in situations that does not involve too much responsibility or temptation. Epileptics may be employed in certain sheltered situations, if they have an aura, are under treatment, have not previously injured themselves, and are capable of handling themselves in case of a fit. If an epileptic is not constrained to conceal his condition, and so does not work in continuous dread of discovery, he is much less apt to have fits, or hurt himself when he does have one. Alcoholism is socially acceptable in certain types of work, particularly those which are dominantly masculine, involve bodily contact with the work, a certain type of male rivalry and grueling hours. It is likely not the work that is conducive to drinking, but rather

the type of person attracted to that type of work is also apt to use alcohol. Where the ingestion of alcohol is excessive for the particular type of work, the applicant is rejected. For example, a certain amount of drinking is condoned in foundry workers, but none at all in test pilots.

After placement, a follow up is maintained. If for any reason the placement appears poor, reassignment or other adjustment is made. This attitude that mistakes will be made, enables all concerned to profit from their errors.

Psychiatrists are in a position to offer valuable service to industry especially in the rehabilitation of veterans, but they must prepare themselves to use facilities already present without interfering with production. This pooling of information and knowledge will benefit psychiatry, industry, the worker and the community as a whole.

# OBSERVATIONS ON CERTAIN INORGANIC INDUSTRIAL HAZARDS

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COINCIDENT with advance in science and technology and especially since the beginning of the war, there has been increasing application of new or untried materials in industry. Some of these substances had been very rare indeed in the past, yet, because of their industrial importance, resource have been uncovered and the substance made more freely available. An instance of this may be cited in the case of indium which, although classified as a rare metal, has received a variety of applications in industry, not the least of which is its use in electroplating cadmium and other alloy bearings for airplane and other high duty internal combustion engines. Increasing use in industry is being made of molybdenum, magnesium, beryllium, vanadium, tungsten, titanium, zirconium, uranium, caesium, and rubidium. Knowledge of the toxicity of these substances is scanty at best and the effects of industrial exposure to the metal fume or dust of ores or compounds has received investigation in but very few instances. Frequently information regarding industrial poisons in the past has unfortunately become available only after years of exposure have elapsed and irreparable damage to individuals has been done. Substances have often been used freely in the arts or in manufacturing with no knowledge of their toxic qualities, nor with any warning of precautions to be observed in their use. This has perhaps been due not so much to negligence as to ignorance. As a consequence there have been occasional flare ups of mass poisoning in industry, which in several cases were attended with fatal results. To offset this, there is a growing tendency among toxicologists to anticipate these dangers by defining the toxicity of such substances before they receive extensive use.

In addition to the use of new and untried substances, one finds new ways in which substances known to be toxic are used, or unforeseen ways in which toxic substances are introduced in manufacture which often lead to damage or fatalities in industry. It frequently requires considerable ingenuity on the part of the industrial hygienist to detect this source of danger.

The hazards of exposure to deleterious substances were formerly designated by industries. For instance, it was customary to group industrial hazards under such headings as the petroleum industry, sulphuric acid industry, the coal-tar industry, etc. This distinction is no longer useful, since such a wide variety of substances are in use and because of the overlapping of many industrial operations.

An estimate[1] made in 1940 of the number of workers in the United States who are exposed to various potentially dangerous inorganic substances indicates 1,142,503 exposed to silica, 783,076 exposed to lead and its compounds, 250,226 to sulphur dioxide, 135,182 to hydrogen sulphide, 99,338 to antimony and its compounds, 34,251 to arsenic, 32,855 to mercury, and 14,007 to phosphorus. Furthermore a large group of 2,254,306 workers is

*Presented on April 25, 1944, as the seventh in a series of ten lectures on "Toxicological Problems in Industry" as part of seminar in pharmacology for senior medical students and interns, Yale University School of Medicine*

exposed to all other metals, many of which are innocuous, which of course includes small groups potentially exposed to very dangerous materials.

With the enormous expansion of industry relating to war production, the number of workers exposed to these substances must be very substantially increased and furthermore many more new and untried substances are in use in industry than would probably be used under normal conditions. Many of these substances are being used as substitutes for more strategic materials, while others represent new and important and often secret uses. This has placed a burden on the industrial hygienist who, in view of the rather sketchy information available concerning these substances, is often at a loss in making recommendations for the protection of workers.

The type of exposure which is most hazardous with the possible exception of active skin poisons, is that of inhalation of dusts, fumes, or gases. While accidental ingestion of inorganic poisons is comparatively rare, apparently poisoning as a result of this type of exposure is more generally familiar than that of inhalation. As a matter of fact, poisoning from the ingestion of the toxic materials of industry is less frequent because of the hygienic facilities of large establishments and because of increased awareness of both employer and worker with regard to cleanliness. Apart from this, absorption from the alimentary tract is by no means complete especially with many insoluble substances. An adequate diet also may tend to decrease absorption as for instance in the case of lead where a high calcium diet markedly decreases lead absorption.

From an historical point of view the severe lead poisoning resulting from drinking wine sweetened with lead (Citois, 1616),[2] from Devonshire cider (Hardy, 1778),[3] from Jamaica rum (Hunter, 1788)[4] and the many cases since then of poisoning resulting from drinking water or eating food heavily contaminated with lead has probably overshadowed other means of causing lead poisoning, yet the greater danger of breathing lead dust or fume was pointed out more than a century ago by Tanquerel des Planches (1839) and by many others since. Minot[5] found that as much lead may be absorbed from the respiratory tract in one day as may be absorbed from soluble ingested lead over long periods of time. Hence the individual's injury is likely to be much greater when exposed to dust, fume, or gas by inhalation than when he is receiving the same amount of material by mouth.

The inhalation of the fumes, gases, or dusts of metals or their compounds or of other inorganic substances results in an accumulation of material within the lungs which may cause damage by local irritant action, or which may cause general systemic poisoning. Its removal must depend upon the circulation or upon phagocytic action. Moreover, the total amount entering the body in this way must be regarded as potentially absorbable and the defence mechanism of the liver plays only a minor part in its removal.

Injury by this means may range from acute systemic poisoning resulting from inhalation of a gas, such as hydrogen sulphide or arsine, or the pneumonitis caused by locally irritant particulate material such as cadmium oxide fume or that of certain fluorides to the slowly progressive condition typified by chronic lead poisoning or silicosis.

These industrial poisons may enter the body through the respiratory system, the digestive tract, through the skin, or by a combination of these channels. The effects are either acute or chronic and vary in severity from the fatal attack of chlorine or arsine poisoning to the chronic intoxication of lead, arsenic, phosphorus, mercury, etc. Many of the industrial poisons produce both acute and chronic effects. In the acute form, profound functional disturbances are caused by an overdose of the various blood and nerve poisons; in the chronic form, because of diminished dosage, the poisons may cause disease of a progressive character by producing gradual histological changes of the blood and tissues of the body. There are doubtless numerous instances in which minute quantities of poison are not sufficient to produce specific effects and yet do bring about a general deterioration and diminished power of resistance, as instanced by the prevalence of incidental disease—for example, the reputed prevalence of tuberculosis among mercury[6] and vanadium[7] workers.

As in infectious diseases, so in occupational intoxication, dosage, individual susceptibility, a low state of vitality, previous illness, bronchial and gastric catarrh, wounds and abrasions of the skin, and the use of alcohol are predisposing factors. Since most of the poisons are eliminated by the lungs, liver, kidneys, and skin, functional derangements of these organs also play an important role.

There is the selective affinity of industrial poisons for certain organs or tissues. Lead apparently attacks the nerves of the overworked muscles of a painter's

arm and causes the paralysis commonly called "wrist drop." White phosphorus shows a special affinity for carious teeth, and aids the germs in their destructive work of bringing about necrosis, or the "phossy jaw" of the matchmaker. Radium poisoning causes necrosis and suppuration of the bones, particularly the jaw bone. Hysteria and neurasthenia develop as a result of chronic poisoning from such widely differing substances as manganese and mercury.

In order to evaluate industrial poisons quantitatively it is necessary to determine (a) somewhat exactly the conditions which produce acute poisoning, and (b) those conditions that may produce chronic poisoning, where there is any evidence of the latter. This usually involves a considerable amount of animal experimentation. The initial experiments define the minimum lethal dose or amount of poisonous material just necessary to kill an animal. This may vary somewhat from one animal to another, but by making a sufficiently large cross section it is possible to arrive at a fairly representative figure. None the less in general one must treat figures for minimum lethal dose with reserve.

With respect to gases or to absorption of poisons by the skin, the procedure itself is straightforward with no particular technical difficulties. What difficulties there are here usually lie in the interpretation of results. With dusts or fumes, however, the experimental procedure is somewhat more difficult. It is necessary to know something about the size of the dust particles. Information is also required concerning the amount retained by the lungs in the animal subjected to study, and finally, something must be known about either excretion or storage and perhaps distribution in the tissues in order to find out what has happened to the material after it enters the lungs and, more particularly, how various organs and tissues are affected.

It would appear that the solution rate may be a matter of some importance. Unfortunately very little data are available with reference to the rates of solution of various substances.

The particle size of a dust under investigation may of course be measured relatively easily. Dust retention in the lungs may be determined by killing the animal and analyzing the lungs in those cases where the dust is relatively insoluble. The volume of air breathed may be measured on a recording spirometer and the dust content can be under analytical control, so that retention may be measured with some accuracy.

What happens to the dust after it reaches the lungs is a much more difficult matter. The localization of injury by dust is not only often difficult—some attempt to find out the chemistry involved in many cases may be necessary before a solution can be obtained. Thus, one is usually accustomed to searching for tissue irritation or response at the point of contact with an industrial poison. There may be cases, however, where local tissues may show no such response. Petrov[8] has shown this to be the case with ultramarine which, while physiologically inactive with reference to the respiratory system, causes anemia and degenerative changes in the kidney. These are due to hydrogen sulphide poisoning. This dust may even cause death of test animals following inhalation. Observation of the respiratory system alone, therefore, in such a case is insufficient evidence to show that such a dust is inactive.

Ingestion as a mode of entry has been made much of in the past with respect to sanitary measures against poison. As stated above, elaborate precautions have been undertaken in the lead industry as a means of preventing the ingestion of lead by the workers along with their food at lunch time, etc. It is of course true that lead poisoning can be produced by the continual ingestion of small amounts of lead. Absorption of any number of substances fr[illegible] the alimentary tract, particularly organic compounds, will produce both acute and chronic poisoning. However, protection exists to some extent, d[illegible] (a) to the fact that many industrial poisons are either insoluble or are converted to insoluble compounds so that absorption through the intestinal wall is somewhat minimized, and (b) to the rather effective sentry like role played by the liver.

It is by inhalation that the worker is most likely to be affected by industrial poisons. Apparently there is no very good protection against the soluble or protoplasmic poisons on inhalation. As has been stated, material absorbed from the gastro-intestinal tract is to some extent bypassed by the liver. However, material entering the lungs can not be removed as readily and is much more of a menace. Part of it, the coarser material in the upper respiratory tract, may be removed mechanically by the ciliary epithelium and coughed up or swallowed. Part of it, the very fine material carried to the alveoli, may be removed by phagocytic action. The greater part of soluble material must enter the blood stream and is not carried directly to the liver for removal, as is the material from the gastro-intestinal tract. Instead,

the entire circulatory system may be involved. There is, then, this important difference between entrance of a poison by ingestion and entrance of a poison by inhalation in that in the former case small quantities of toxic substances absorbed from the alimentary tract are to a much greater extent blocked by the very effective excretory mechanism of the liver and kidneys. This point should be emphasized because the older literature does not particularly stress this distinction—a distinction, however, that one should keep in mind in dealing with many industrial poisons.

There is still much that is obscure about metallic poisons where only minute quantities are concerned. For instance, the selective action of certain protective cells—particularly in the liver—in dealing with a soluble poison is but imperfectly understood. These matters do not lend themselves readily to experiment, because the conditions (usually of chronic poisoning) are difficult to reproduce in the laboratory and are very time consuming. Another factor of importance is that industrial conditions are changing at the present time. One no longer finds the heavy exposure which characterized industry a generation ago. Therefore, not only are the effects of these smaller quantities of toxic substances more difficult to trace, but the means by which this is made possible—the exact chemical determination of these minute amounts of material becomes increasingly difficult with decreasing amounts of material and in the presence of relatively large amounts of interfering substances.

There is a decided lack of information concerning the toxicity of a number of rare metals and their derivatives. These substances were considered more or less as laboratory curiosities in the past decade, but some of them have now assumed a role of some importance particularly with regard to our war program.

Since information is lacking or incomplete concerning these substances and since they are being used so extensively, efforts are now being made to determine their toxicity and to form some sort of opinion with reference to allowable concentrations of these substances in work rooms. Certain of these substances are used in special steels such as molybdenum, tungsten, vanadium, and lead. Others are found in the form of special alloys, such as the beryllium-copper alloys, which enter into the composition of special materials used in the arts or manufactures.

Beryllium, which was formerly very scarce and very expensive and which would seem to have but little practical use in industry, is now a metal of great importance. When alloyed with copper the resulting metal has a fatigue resistance so great that it has not definitely been measured. The copper-beryllium alloy containing three per cent or less of beryllium is strong and tough as steel, is a substitute for bronze, has a high electrical and thermal conductivity, it possesses a fatigue resistance greater than any other metal and it is, therefore, apparent why it is very useful in oil and gasoline pipe lines on airplanes which are subject to intense vibration. It is also used in diaphragms of altimeters or special instruments of airplanes requiring delicate springs which are subjected to continual stress. A few years ago beryllium was designated as a somewhat poisonous substance by a few investigators and various industrial diseases were described such as berylliosis and beryllium rickets from contact with the derivatives of beryllium. It has been shown[9] recently, however, that beryllium so far from being poisonous is actually less poisonous than magnesium and the results which have been attributed to beryllium in the literature have been due to its combination in such forms as the fluoride. The toxic properties which have been attributed to beryllium in reality are attributable to the fluoride portion of the molecule, or to local irritation on inhalation owing to the extensive hydrolysis of the beryllium salt particulate material, since beryllium salts are highly hydrolysed in solution.

On the other hand vanadium has shown a strikingly poisonous action. Vanadium is important in the manufacture of steel because it also has a high fatigue resistance although this fatigue resistance is less than that of the beryllium alloys. Furthermore, it has the property of toughening steel to a marked extent. Vanadium steels have a wide variety of application such as in tools, in crank shafts for automobile and Diesel engines and in the spring leaves and rear axles of motor cars. Our supply of vanadium is largely imported from Peru where a large deposit exists in the Cerro de Pasco region. Exposure doubtless occurs in trans-shipping the ore which is chiefly the mineral patronite, a vanadium sulfide. In experimental work in this laboratory it has been found that animals exposed to dust from red patronite ore for as little as one half hour die within two or three hours. As in most cases with reference to the other constituents entering into special steels,

once the alloy is made, further contact with it such as ordinary handling or machining is of no hygienic significance. In addition to its use in alloys, vanadium is used as a catalyst for converting such substances as naphthalene into phthalic anhydride, anthracene into anthraquinone, and toluene into benzaldehyde and benzoic acid. In the conversion of sulphur dioxide into sulphuric acid it is far less expensive than platinum, is not poisoned by arsenic or hydrogen chloride, and steadily converts 97-99 per cent of the reactants.

The importance of vanadium in industry is indicated by the great increase in imports and consumption which, for instance, in 1937 more than trebled those of 1936.[10]

In spite of its pronounced toxicity, the number of cases of vanadium poisoning in industry has been small. This is probably due to the method of extraction. Since only small deposits have been found outside the Peruvian and South American sources, vanadium-poor countries have extracted vanadium from certain ores or minerals, coal ashes, asphalt, and petroleum residues. Most of these extraction procedures are carried out in the wet way.

It appears to be the case both in this country and in Germany[11] that only the workers themselves appear to be aware of the effect of exposure on health. Symanski, in his review of nineteen cases of vanadium poisoning, points out the acutely irritant effect of vanadium compounds and recommends the mechanization and enclosure of all such work processes which are dusty in nature.

Led-loy is a comparitively new steel product manufactured very simply by the addition of lead to the charge of iron in the blast furnace. It is said that in adding the lead at this point in manufacture part of the lead is immediately boiled off. The residual lead, however, combines with the iron not as a true solution of lead and iron but as particulate lead scattered through the mass of metal. The properties of the finished steel which contain approximtely 0.25 per cent lead are exactly similar to ordinary steel but the presence of lead in the metal apparently allows machining operations to progress much more rapidly than is possible with ordinary steel. Machine operations can be speeded up with the use of this alloy from 20 to 100 per cent with an average increase in output of 40 per cent. In anticipation of the possible hazard involved in the fabrication of this steel, careful control was instituted in the steel industry making this alloy with the result that no clinical evidence of abnormal lead absorption among employees has occurred.[12]

The increased use of cadmium in industry has largely resulted from its use in electroplating. Somewhat parallel with this increase there has been an increased amount of poisoning. In general the latter has not been primarily due to the electroplating process, but to the subsequent firing or welding of cadmium plated material or the overheating and oxidation of cadmium metal. Cadmium is but little used as a metal directly. It achieves its greatest importance as a constituent of alloys and in the form of its compounds. In this way it is used in bearing metals, electrical conductors, pigments, ceramics, in process engraving, cadmium vapor lamps and for rust-proofing tools, wires and other iron and steel articles, particularly marine hardware and other fittings, which were formerly zinc coated.

Most often fatalities from cadmium poisoning have resulted from inhalation of the fumes of cadmium oxide, rather than the ingestion of cadmium salts. The first symptoms of industrial cadmium poisoning are usually dryness of the throat, cough, headache, vomiting and a sense of constriction of the chest. The latter symptoms are referable principally to the respiratory system and are characterized by cough, pain in the chest, severe dysphoria and prostration. These symptoms result from a pneumonitis which in many instances is followed by broncopneumonia. Unfortunately, cadmium oxide fumes have no pronounced odor nor immediate irritant effect and can be breathed in fatal concentration without enough discomfort to drive the worker away from the exposure.

In view of the extent and severity of cadmium poisoning in industry, a concerted educational effort has been proposed to appraise both manufacturers and users of the hazards involved in the use of cadmium coated products and safety regulations have been proposed defining the degree of maximal permissible exposure of industrial workers.[13]

In the alloy field, molybdenum has taken on new significance within the past few years and mines and mills have been operating at capacity to meet the demand for this metal. More than 70 per cent of the world output of molybdenum comes from a single mine in Colorado. This metal has the property of forming an alloy with steel which is extremely tough and resistant beyond that of many of the ordinary steel alloys. It is especially important in the fabrication of cannons, armour plate, and thin steel

necessary in the wings of airplanes where weight is a matter of great consequence. Molybdenum burns when heated to a high temperature or when heated in the electric arc forming dense clouds of molybdenum oxide fumes, and when hot molybdenum steel is rolled surface oxidation occurs with the evolution of white fumes of molybdic oxide. Molybdenum has recently been found in our laboratory to be somewhat toxic although not comparable to vanadium in this respect.

Previous to the closing of the Burma Road, China was the chief source of supply of the very important metal tungsten. Tungsten is also important in the preparation of high speed steels, and in cemented tungsten carbides and in electric light and radio tube filaments. Cemented tungsten carbide is used as an abrasive containing tungsten, titanium, and carbon. These abrasives are long lived, are extremely hard and are very important in industry. The high speed tungsten steels can maintain a sharp cutting edge even when the lathe tool becomes red hot in machining operations. The tungsten carbide alloy is a substance which ranks next to the diamond perhaps in hardness and which is being produced in large quantities for special tips to tools used in machine operations. High speed tools containing an 18 per cent tungsten alloy, for instance, will "rough out" a 75 mm. shell in 38 seconds as compared with the 12 minutes required with tools of ordinary steel; it is said that one man with tungsten steel tools can produce as much as five men with carbon steel tools.

Tungsten is admittedly somewhat toxic but the extent to which exposure can safely occur has heretofore received no particular attention.

While these and many other substances are or have been under recent investigation, the pace of industry is so great and this type of investigation is necessarily so extensive and time consuming that it is difficult for the industrial hygienist to keep step with industry.

In general there is a tendency in industrial hygiene to seek out the level of physiological tolerance and to try to maintain working conditions at that level, or at lower concentrations with respect to industrial poisons. Hence the many attempts to define and establish standards for permissible working concentrations.

However, the present trend with reference to occupational disease is largely in the direction of prevention and the enclosure of processes is recommended wherever practicable. In many cases, of course, this is impossible and other safety measures are necessary, such as the wearing of respirators of a type suitable to the hazard involved, the use of protective clothing, or the installation of especially devised ventilation systems.

While much has been accomplished of an educational nature with respect to the dangers of many toxic substances freely used in industry, small establishments frequently maintain unhygienic working conditions due either to ignorance of the hazards involved, or to the cost of installation of protective equipment. The need of more widespread information in this field cannot, therefore, be too strongly emphasized.

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# THE TREATMENT OF ASPHYXIA

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ASPHYXIA is a chemical phenomenon. In the severe forms of this disorder the blood is almost depleted of oxygen, there is an increase in the partial pressure of carbon dioxide, and there is a sharp rise in blood lactic acid. While these changes in the lactic acid, pH, and carbon dioxide tension are marked, it should be remembered that they are entirely secondary and that the primary blood chemical change in asphyxia is an extreme reduction in the oxygen content of the blood.

Severe hypoxia is quickly followed by extinction of life; and lesser degrees of oxygen deficiency rapidly manifest themselves in anatomic and physiologic disorders and sometimes result in permanent damage.

It is, therefore, obvious that the treatment of any oxygen deficiency state calls for immediate and rational treatment; and this means supplying oxygen to the tissues.

Waters[1] has said, "Practitioners of medicine rush to the telephone to call rescue squads from the police and fire departments while patients die who could be rescued. To the disgrace of present day medical education, sudden failure of respiration is not a rare cause of death in the wards and operating rooms of the modern hospital."

Behnke[2] has aptly said, "The vast body of knowledge concerning respiration stands in contrast to the lack of organization and equipment for the initiation and maintenance of adequate breathing."

Volpitto and Torpin[3] have called attention to the bewilderment of the average physician by the multiplicity of theories and methods for reviving the asphyxiated newborn.

The size of the clinical field presented by problems of asphyxia, when infants are included, is shown by the fact that probably 3 to 4 times as many such deaths occur as from automobile accidents.

In theory there is no difference in principle between infants and adults in the treatment of asphyxia. Practically, however, full preparation can be made for the care of asphyxia of the newborn, because its time and place can be predicted, while adult asphyxia may occur anywhere and at any time.

For this reason it becomes a matter of convenience to consider the resuscitation of infants and adults separately.

### INFANT RESUSCITATION

The total infant mortality in the first day of life in the United States is more than 110,000 yearly. The prime factor in infant deaths in this first day of life is asphyxia. It is not possible to estimate the morbidity, but recent investigations[4,5] have shown that it is enormous.

It is not the purpose of this paper to discuss the etiology of asphyxia; for this the reader is referred to the excellent treatise by Eastman.[6] Here the main concern is to call attention to some recent advances in the treatment of this condition.

Prevention of asphyxia calls for good prenatal care and management of labor, great care in the employment of sedatives, and the avoidance of oxygen deficiency during anesthesia. Emphasis must be placed on the carrying out of a rigid routine of resuscitative care immediately after birth.

The problems of treating neonatal asphyxia in no small measure revolve around the many faulty practices which are widespread. Among these may be listed the following: swinging the baby, dilating the sphincter, spanking, dousing with ether, hot and cold tubs, and all other forms of external stimulation. Because of the danger of brain hemorrhage it is self evident that to hold a baby head down is exactly the wrong thing to do.

Alpha-lobeline, metrazol, picrotoxin and coramine as well as all other so-called stimulants have no place in the treatment of apnea at birth because their effect on respiration is nil in the presence of anoxia; and it has been shown, the severe forms of apnea neonatorum are regularly associated with anoxia.[7]

*Presented at 20th Clinical Congress, Connecticut State Medical Society, September 29, 1944*

Mousel and Essex[8] in working with these drugs have found that not only are they of no value in stimulating respiration and circulation when these centers are depressed, but that they actually increase the depression, often cause convulsions and they may even cause sudden cessation of respiration and death.

In experimental asphyxia pure oxygen is superior to carbon dioxide-oxygen mixtures as a resuscitating agent.[9,10] The addition of carbon dioxide in the treatment of apnea is not only superfluous; it is actually harmful. There is no lack of carbon dioxide in such cases. When the medullary centers are damaged, carbon dioxide is a depressant.

Manual methods of artificial respiration should not be attempted in the resuscitation of the apneic newborn for the simple reason that one cannot express air from an airless lung and damage to the viscera and ribs occurs not infrequently.

The respirator chamber types of apparatus are of little or no value in the treatment of apnea neonatorum. Murphy and Bauer[11] and others report that the lungs show little or no aeration following the use of such apparatus.

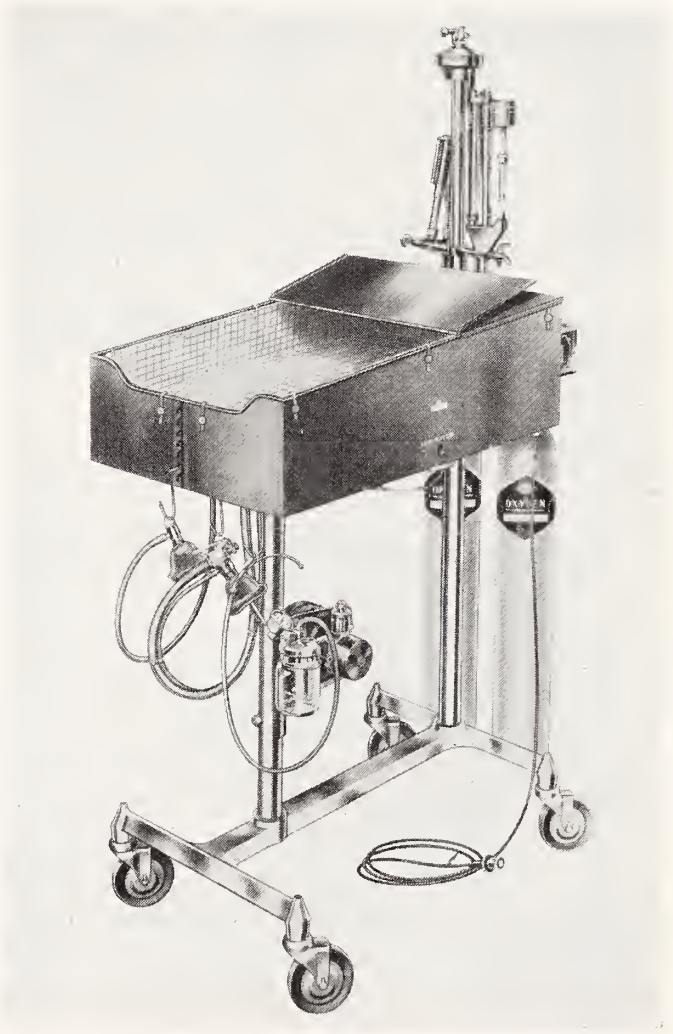
The pulmotor types of resuscitators are of the automatic suck and blow principle; they are not efficient in the treatment of apnea neonatorum. The lungs of these patients have never contained air and the machines, upon meeting the resistance of the atelectatic lungs, trip back and forth without inflating the lungs sufficiently.

It is, of course, necessary to know what to do as well as what to avoid. Since most babies are born in hospitals, it is obvious that adequate apparatus for treating this condition should be made available. Here is an opportunity not only to keep asphyxial mortality at an absolute minimum, but also to prevent many of the complications which later arise as a result of asphyxia.

### ESSENTIALS OF TREATMENT

The essentials of successful treatment of asphyxia neonatorum are maintenance of body temperature, correct posture for maintaining an open airway, clear air passages, and the administration of oxygen intermittently under positive pressure or continuously at atmospheric pressure.

An apparatus for the resuscitation of apneic newborn babies was first described by Kreiselman, Kane and Swope in 1928.[12] This apparatus has since been improved and additions have been made so that it now embodies in one compact unit all of the requisites for the successful treatment of asphyxia of the newborn.[13]



Body heat is maintained by a thermostatically controlled, electrically heated bassinet. The correct posture is obtained by adjusting a tilting platform on which the baby is placed. Clear air passages, a prerequisite to any satisfactory method of artificial respiration, are maintained by an effective, electrically driven aspirator.

Oxygen is supplied to the lungs intermittently at a carefully controlled and predetermined pressure. This pressure may be regulated up to 16 m.m. Hg., and is indicated at all times by a water manometer gauge, which also acts as a water safety valve and makes it impossible to apply too great a pressure. The average pressure used is 12 m.m. Hg. The rhythm and rate are controlled by the operator.

A rubber face mask fits over the nose and mouth, and at its apex apertures are provided for admitting the oxygen. On the inside of the face mask there is

attached a stiffly flexible rubber airway, or breathing tube, which extends over the tongue into the pharynx. A valve on the face mask is so designed that there can be no intereference with voluntary efforts at breathing. Continuous flow oxygen is available through a mask which has no valves or bags to get out of order, or to interfere with respiration. There is also provided a small head tent for administering oxygen over longer periods.

ROUTINE TREATMENT

The routine in caring for the newborn in hospitals in which this apparatus is in use is as follows:

As soon as the cord is cut the baby is placed in the heated bassinet in a 15° Trendelenberg position. The mouth and pharynx are cleared at once with the aspirator, and if the baby does not breathe spontaneously, or if it is cyanosed or pale, oxygen is given without delay.

A common error is waiting to see what will happen. Do not wait. Supply oxygen to the tissues immediately. No harm can be done by so doing, but delay may be fatal or may result in irreparable damage to the central nervous system. Progression of asphyxia may proceed with extreme rapidity. Therefore time is of utmost importance in the treatment. It is easy to correct mild asphyxia but difficult to correct it when it becomes profound.

If the baby is not breathing, oxygen should be supplied with the resuscitator by placing the mask over the nose and mouth with the airway over the tongue. The head should be extended and the chin held up in order to maintain a clear airway. This is very important. Depress the valve lever on the mask and hold it down long enough for the lungs to be inflated. Then release the lever and the lungs will deflate because of their own elasticity. Do not remove the face mask, for the expired gas will escape through the mask valve. The lever should be held down for about two seconds, for it is then that the oxygen is taken up by the blood stream. The lever is then released and about two seconds is allowed for the lungs to deflate. The rate should therefore be about 12 to 15 inflations per minute.

In deeply asphyxiated babies, breathing efforts will begin usually with spasmodic inspiratory efforts, which do not take in air. These efforts should be carefully watched and the inflations synchronized with each effort at inspiration, at the same time continuing the 15 times per minutes rate. This timing can be accomplished only through use of an apparatus the rhythm of which is controlled by hand operation.

When breathing is established, but oxygen is still needed, the face mask with the attached airway should be removed, the continuous flow mask placed over the mouth and nose and the flowmeter set at four liters a minute. This procedure applies also in asphyxia when the baby is breathing, but needs oxygen. If oxygen is needed over a period of hours or days, place the tent hood over the head and set the flowmeter at four liters. This will give an oxygen concentration of about 70 per cent.

When the asphyxia is of mild or moderate degree, it is not necessary to intubate the trachea. To do so may be difficult; it may even prove harmful. In profound asphyxia, when the larynx is relaxed, tracheal catheterization may be done without the same dangers of injury to the larynx and trachea. Provision is made for the attachment of a tracheal catheter in place of the face mask.

Tracheal catheterization is best achieved by direct vision with a laryngoscope and it should be practiced only by those experienced in the procedure. A special rubber catheter, which cannot be introduced too far and which helps to seal off the larynx, should be used.

Efforts at resuscitation must always be continued without interruption. Often babies will improve in color and heart action, but they may not breathe spontaneously for a long time. Chemical changes have taken place and it is necessary to reverse these changes. Then too, time is necessary for the elimination of drugs which may have been given the mother.

In the absence of suitable apparatus mouth to mouth or mouth to tracheal catheter is the best method. This should be combined with the above principles. The drawbacks in this method are the inaccuracies in judging pressure, the difficulty in keeping a clear airway, the low oxygen content of the expired air of the operator and the danger of infection.

ADULT RESUSCITATION

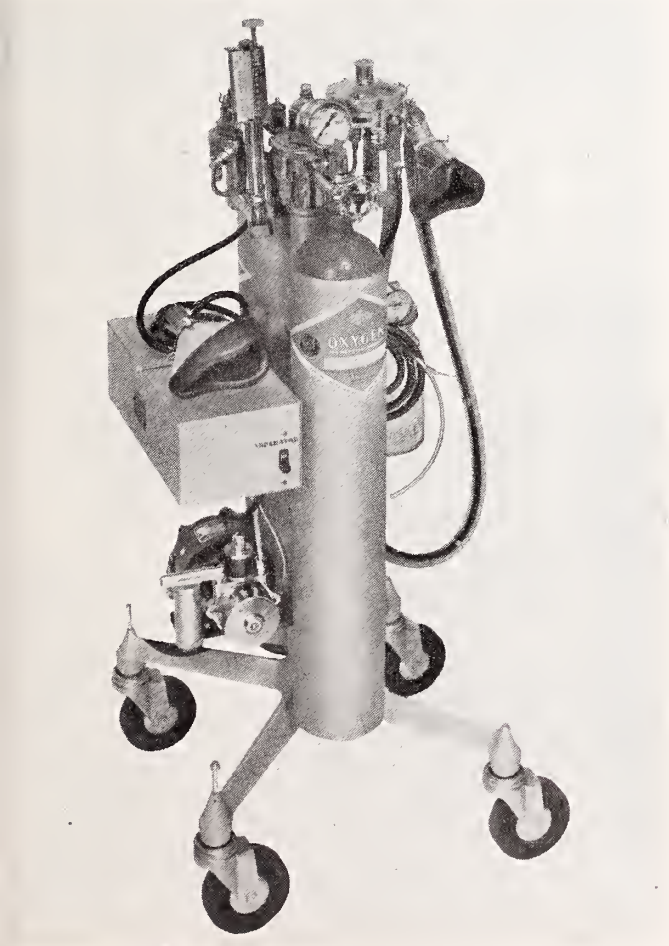
It is necessary to consider this clinical problem as a separate entity because adult anoxic collapse may occur anywhere and at any time. Therefore it must be stressed that the first person on the scene must initiate manual artificial respiration at once. Thus, widespread training in method is needed.

There are many faults with the manual methods

of artificial respiration.[14,15] The aeration of the lungs, even in the hands of experienced operators, is often ineffectual and certainly variable. It is, however, necessary to learn the manual methods and to learn them well; for these methods are difficult to perform and they are very tiring.

The oustanding essential in adult resuscitation is effective pulmonary ventilation and in hospital practice this can be accomplished by inflating the lungs with oxygen, using an anesthetic machine. However, one must be familiar with the machine and he must make sure that excessive amounts of carbon dioxide are not built up.

Effective pulmonary ventilation can be accompilshed by the use of an adult resuscitator that is similar to the infant one, but capable of delivering pressures up to 25 m.m. Hg. The pressure required to inflate the adult lung is seldom in excess of 20 m.m. Hg.



Since manual methods are frequently difficult and unsatisfactory, or even impossible to perform in the presence of chest and back injuries and in many other instances, and because it is usually not possible to have a large hospital type resuscitator at hand, it is imperative to have a device so simple that anyone can be trained to use it in a few minutes.

Now, for the first time, we have a resuscitator that is simple in construction and easy to operate.[16] It is portable, can be stored in a small space, since it is 5¾ inches in diameter, four inches in height, and weighs less than two pounds. Because the device is simple and portable, routine drills can be carried out to insure the availability of large numbers of trained and competent operators.

Because of these features it can be made available wherever there are undue hazards that may cause respiratory failure.

The apparatus consists of an expansible bellows type bag of 1500 c.c. capacity, a face mask, and a valve placed between them. There are valves for the intake of air and oxygen and a safety valve which limits pressure to 20 m.m. Hg.

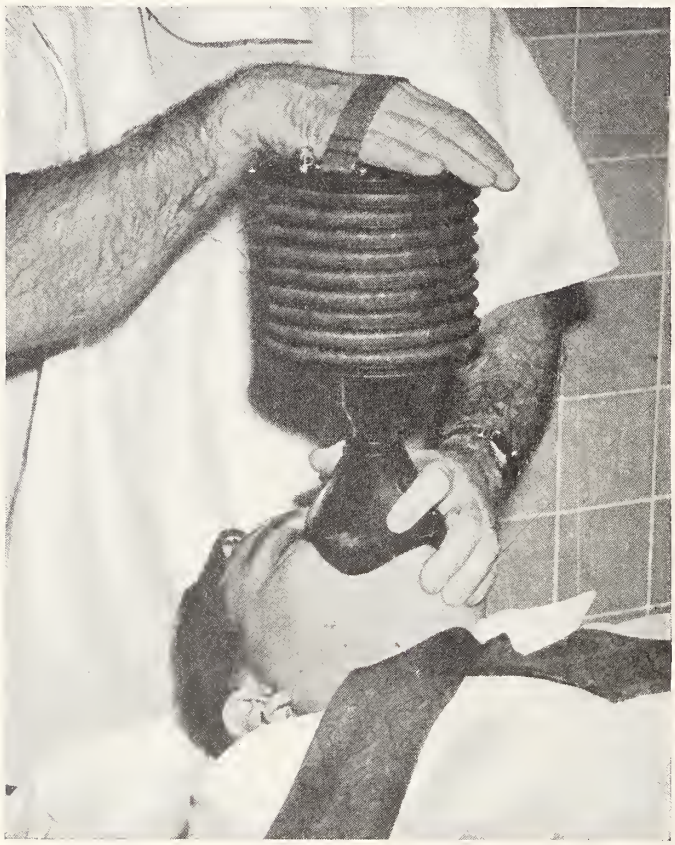
This resuscitator may be operated with either air or oxygen. Inflation of the lungs may be started immediately with air and, if necessary, oxygen can be added when available without interrupting the procedure. In the absence of obstruction, an effective and satisfactory respiratory exchange may be initiated and maintained. Resuscitation is, therefore, placed on a simple and effective basis.

When the apparatus is at rest, there is free communication between the patient's lungs and the outside air and communication between the patient's lungs and the bag is automatically shut off. When the bag is raised, by placing the hand in the handle at the top of the bag and lifting it, the bellows fills with air through an intake flap valve. During this operation, as well as when the apparatus is at rest, there is free communicaton between the patient's lungs and the atmosphere. It is, therefore, possible for the patient to begin breathing freely and of his own accord at any time without interference.

Then by compression of the bellows the intake flap valve is closed, whereupon the main valve is activated, closing the communication between the patient's lungs and the outside air, and establishing a communication between the contents of the bag and the patient's lungs. The air now passes into the lungs at a pressure less than 20 m.m. Hg., the setting on the safety valve. When the pressure of the hand against the bag is released, following inflation, the main valve leading to the bag is immediately closed,

and the gases in the lungs are expired directly into the outside air. The lungs deflate because of their own elasticity. A mixture of the gases from the lungs and the air or the oxygen in the bag is impossible. This fact is of the greatest importance because by this method the lungs can be rid of noxious or inert gases in the shortest time and it is impossible to build up carbon dioxide. It is obvious, then, that each new bagful contains pure air, oxygen, or a mixture of the two.

The bellows is operated at the normal respiratory rate of about 15 per minute. When oxygen is used, a tube leading from an oxygen supply is attached to the oxygen inlet tube on the apparatus, and a flow of 5 to 6 liters per minute is introduced. This would give between 50 and 60 per cent of oxygen if 500



c.c. (normal tidal volume) is used for each inflation. It is necessary to inflate the lungs only to a point where the chest is seen to rise. It is neither necessary nor desirable to empty the bag completely.

When the patient, who has been apneic, begins to breathe, the initial respiratory efforts are usually irregular and feeble; and the patient does not take in sufficient air or oxygen. When this occurs, with each effort at inspiration the bag is compressed, at the same time continuing the regular rate of about 15 times per minute. When regular breathing has been established, the resuscitator is removed.

By using an elbow* which is supplied with the apparatus the operator may combine the use of this resuscitator with the prone pressure method of artificial respiration and thereby greatly increase its effectiveness. This requires the presence of two operators working rhythmically. It may be the best method following immersion when drainage of fluid is desired. If possible the patient should be placed in a 15 to 20 degree angle with the head down.

Following each manual compression of the chest, the lungs should be inflated with the resuscitator. A definite rhythm should be maintained and the rate should be 15 per minute.

The mouth and pharynx should be kept clear of all foreign material. A clear unobstructed airway is essential for the successful performance of any method of artificial respiration. It should be further stressed that lung ventilation is the ultimate essential in resuscitation; it must be initiated at the earliest possible instant and must not be interrupted for any other form of supportive care.

In summary:

1. An apparatus has been described which fulfills all the requirements for the successful treatment of asphyxia in the newborn.

These requirements are: maintenance of body temperature, correct posture for sustaining a clear airway, efficient aspiration and the supplying of oxygen to the lungs intermittently under positive pressure or continuously at atmospheric pressure.

2. An adult resuscitator for hospital use has been mentioned which embodies the principles of the infant resuscitator.

3. A new apparatus for performing artificial respiration in the adult has been described. This apparatus meets the requirements for satisfactory and safe inflation of the lungs, using a simple technic. It is small, light, inexpensive and mechanically simple.

4. Both apparatus operate to inflate the lungs at safe, controllable pressures.

5. Normal respiratory exchange with atmospheric air can take place while the apparatus is applied.

6. When breathing begins, the patient is always in free communication with either air or oxygen.

7. The rhythm and rate are controlled by the operator. This is of utmost importance because the patient's efforts at breathing can be reinforced by

he operator and the patient is not compelled to breathe against a rhythm which is not attuned to his own.

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# THE PRESENT STATUS OF TREATMENT IN ANGINA PECTORIS

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There is considerable difference of opinion about the value of treatment in angina pectoris. From time to time reports appear concerning new therapeutic agents with sufficient promise to warrant general trial. In the course of a few years, however, such methods are either discarded because of later adverse reports, are dropped because clinical experience fails to substantiate the earlier results, or are replaced by new methods of treatment.

Most evaluations of new therapeutic agents report that the method was found of considerable value in at least 75% of patients and failed in surprisingly few instances. This is true irrespective of whether the therapeutic agent advocated is a simple drug to be taken by mouth, a time consuming and costly method such as x-ray therapy or a difficult and even dangerous surgical procedure. Obviously, if the beneficial effects of any one of these methods proved to be as good as first reported, there would be no necessity for new improvements in treatment. In sharp contrast to these studies, a few investigators have attempted to compare the effect of specific with that of obviously inert therapy and have come to the conclusion that no method of treatment is of any value.[1,2]

The reasons for this great difference of opinion and the reasons for the difficulty in evaluating the benefits of therapy are many. The clinical course of

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*Presented at the Twentieth Clinical Congress, Connecticut State Medical Society, New Haven, September 28, 1944.*

the condition varies tremendously, and any improvement observed during the course of study is likely to be attributed to the drug. The factors responsible for the frequency of attacks in daily life are varied and are difficult to control and evaluate. The mental attitude of the patient and observer towards a new method of treatment is difficult to eliminate and is of considerable importance in therapy and its evaluation.

A further difficulty arises from the fact that many investigators have attempted to demonstrate the value of therapy by the use of experiments in laboratory animals. Such studies are of limited value in investigating angina pectoris and in many instances have obscured the clinical facts. The group of symptoms which we call angina pectoris exists, so far as we know, only in man. A great many factors are involved in producing these symptoms. These include: 1. The underlying obstruction to coronary blood flow and the adequacy of the collateral circulation. 2. The various mechanisms which together determine the nourishment of the myocardium, such as the heart rate, blood pressure, rate of blood flow, utilization of oxygen by the tissues, ability to remove toxic products, cardiac reflexes etc. 3. The requirements of the myocardium in order to perform the necessary work; this again includes the frequency and strength of contraction, the head of pressure and various reflex factors. 4. The ability of the patient to experience pain, which involves among other things reflex and psychic factors. Animal experiments, as a rule, investigate only one of these factors (most commonly the rate of coronary blood flow) and fail to measure the important balance between the supply of blood and the demands of the myocardium and its result in terms of discomfort.

The truth of the value of therapy in angina pectoris apparently lies somewhere between the more optimistic and more pessimistic views. During the past ten years objective evidence, uninfluenced by the impression of patient or observer, has accumulated which shows that certain therapeutic agents have a definitely beneficial action in the treatment of some patients with this condition.

In 1933 Wayne and LaPlace[3] showed that following the use of certain drugs (notably Nitroglycerin) patients with Angina Pectoris could do a greater amount of work than was possible when not taking the drug.

This form of study has been carried further in the Angina Clinic of the Beth Israel Hospital of Boston.[4,5,6,7,8,9,10,11,12,13,14] It was found that the amount of work necessary to precipitate attacks of angina is remarkably constant if the patient works under certain standardized conditions including, especially, exposure to cold.[4,12] *Since the majority of attacks in daily life come on exertion, any method of therapy of value should permit the patient to do more work under these standardized conditions before pain begins.* Although patients frequently experience periods of freedom from pain unrelated to treatment, there is, nevertheless, a close correlation between the results of these studies and clinical experience. Patients who are able to do at least 100% more work under these standardized conditions following medication are usually free from attacks during daily life. An increase of 50% in the exercise tolerance is usually accompanied by moderate clinical improvement. An increase of 20% or less is not associated with any demonstrable clinical improvement.

Between 1938 and 1941 Levy and his coworkers[15,16,17] demonstrated that the administration of certain drugs prevented, diminished, or delayed the onset of characteristic changes in the electrocardiogram induced by anoxia. These studies demonstrate objectively that these drugs, presumably vasodilators, do have a pharmacologic effect on the heart and decrease the effect of anoxia.

In 1940 and 1941 Riseman and his coworkers showed that electrocardiographic changes, identical with those induced by anoxemia, also occurred in patients during exertion[18] and could be prevented or diminished by the use of several drugs.[9] These results confirm the results of Standardized Exercise Tolerance studies. Drugs with a vasodilating action permit patients to do more work and at the same time diminish the electrocardiographic changes during exercise. Therapy which permits an increase in Standardized Exercise Tolerance without preventing the electrocardiogram of exertion (eg. cobra venom) act presumably through interruption of sensory impulses. The correlation between these clinical studies during exertion in the laboratory and clinical angina pectoris as it occurs in daily life is obvious.

These objective methods of study have been used, in the Angina Clinic of the Beth Israel Hospital in Boston since 1932, to evaluate the efficacy of 70 different methods of treatment in Angina Pectoris (including the testing of over 100 different brands). The results of these studies emphasize that patients

differ considerably in their ability to respond to treatment.[11] Approximately one-fourth of the patients studied responded to a striking degree to almost any method of treatment which was not inert ("Marked Reactors," Group 1 patients). One-third of the patients responded to a moderate degree to these same agents ("Moderate Reactors," Group 2 patients). The remaining two-fifths failed to respond to most of the available methods ("Non Reactors," Group 3 patients).

Obviously in studying the benefits of any therapeutic agent, the number of "Marked, Moderate and Non Reactors" must be known before the value of the method can be estimated. Furthermore, since it was found that methods of treatment differ considerably in their effectiveness, it is obviously not sufficient to prove that a therapeutic agent is effective, but it is necessary to compare the value of the therapeutic agent with that of other simple inexpensive methods of available therapy. For example, papaverine hydrochloride administered intravenously permits some patients with angina to do more work than is possible without such treatment.[13] This beneficial action is, however, short in duration and moderate in degree. Other methods of therapy, such as the prophylactic use of nitroglycerin or certain purines, are more frequently effective, less costly, and much easier to use.

Consideration of these two factors (i.e. the variation in the response of different individuals to treatment and the comparative efficacy of different methods of treatment) goes far to explain the variation of opinion regarding the practical clinical value of proposed therapy.

The methods of study used at the Angina Clinic of the Beth Israel Hospital, Boston, have made it possible to compare the value of different therapeutic measures on a uniform basis. The method of study, in brief, is as follows: Typical patients with Angina Pectoris are examined once each week in a special clinic. During weeks and months of observation, the actual frequency of attacks of pain in daily life becomes apparent, as well as the psychological make-up of the patient and the degree of physical and emotional activity in his daily life. At each visit, the amount of work which the patient can perform under the conditions of the Standardized Exercise Tolerance Test is measured. Following this initial period of observation, the increase in the amount of work which can be done following the sublingual administration of nitroglycerin serves to differentiate between the "Marked, Moderate and Non Reactors." The effects of various therapeutic agents are studied in a similar fashion. Therapy is administered for a week or longer, followed in each instance by a period during which the patient receives inert medication with the same physical appearance. If a positive response to therapy is observed, the effect is checked at a later date by readministration of the agent in a disguised form. Later, the effect of any apparently beneficial drug on the electrocardiogram during exercise is determined and compared with tracings taken under identical conditions when the patient received inert therapy. This method of study is time consuming and must be interrupted frequently because of spontaneous improvement which may occur in the course of the disease. Such remissions become apparent through this method of study, whereas, with ordinary methods they might be considered therapeutic responses.

Therapeutic methods can be separated into eight groups, the Nitrates, Purines, Cinchona derivatives, Sedatives, Iodides, Therapy acting on the autonomic nervous system, Surgery, and a Miscellaneous group including various drugs and physical therapeutic procedures. Each group contains measures which are of great value, moderate value and no value.

Approximately 22 procedures have been found to be therapeutically effective; 16 of these are of considerable practical value. Of the Nitrites, Nitroglycerin is of greatest value, given either therapeutically of prophylactically in doses of 1/500 to 1/100 of a grain. Amyl-nitrite and Octyl-nitrite are equally effective but are more expensive and not as easy to use. Several Purines are of definite value. These include the Sodium Acetate derivatives of Theobromine and Theophylline, Theophylline Calcium Salicylate, Aminophylline, Theopropanol, and to a lesser extent Glucophyllin. Of this group, Theobromine sodium acetate is most valuable because of low cost in relation to clinical effectiveness and low toxicity. Eight other Purine derivatives in addition to this group have been studied by these methods and were found considerably less effective. Of the Cinchona derivatives, Quinidine Sulphate is particularly valuable. Used in 3 to 5 grain doses four times daily in patients with Coronary Artery Disease with regular rhythm, it is rarely attended by any untoward effects. The value of these therapeutic procedures can be enhanced in some patients by the

judicious use of small amounts of sedatives such as phenobarbital or codeine. Other methods of therapy are distinctly less frequently of striking value, but the use of large doses of Potassium Iodide (1.0 gm., 3 or 4 times daily) or Atropine Sulphate (grains 1/150 to 1/100, 4 times daily) may be of considerable value especially in Group 3 patients to whom other effective methods of therapy are not available. The surgical procedures require careful evaluation. Many different methods of therapy have been advocated and according to the published reports all give strikingly good results. From the reported statistics, there is little choice between them. In our experience, total thyroidectomy is of considerable value in the few carefully selected patients who are suitable. Paravertebral alcohol injection appears to be of some value in others. Surgery, however, is rarely needed; the use of Cobra Venom[15] further decreases the frequency with which it may be required.

In the treatment of Angina Pectoris, the care of the individual patient is most important. Careful elimination of specific factors responsible for many attacks in daily life and the development of a proper mental attitude towards the disease is of paramount importance. Medicinal treatment is usually necessary. As a result of objective studies, it was found that certain therapeutic measures are of definite value in Angina Pectoris. The proper use of these agents will improve the comfort of the patient.

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# HOW THE RED CROSS SUPPLEMENTS MEDICAL CARE

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CONNECTICUT has given a higher percentage of physicians to the armed forces than most other states. Those who remain to serve civilian needs are under strain. The shortage of nurses aggravates the situation. By actual count there are relatively more nurses in Connecticut than in other states, but this abundance is more seeming than real for the reason that industry in Connecticut has absorbed great numbers of nurses, leaving few for usual needs. Relief is not in sight—the Army and Navy are calling for more and more doctors and nurses.

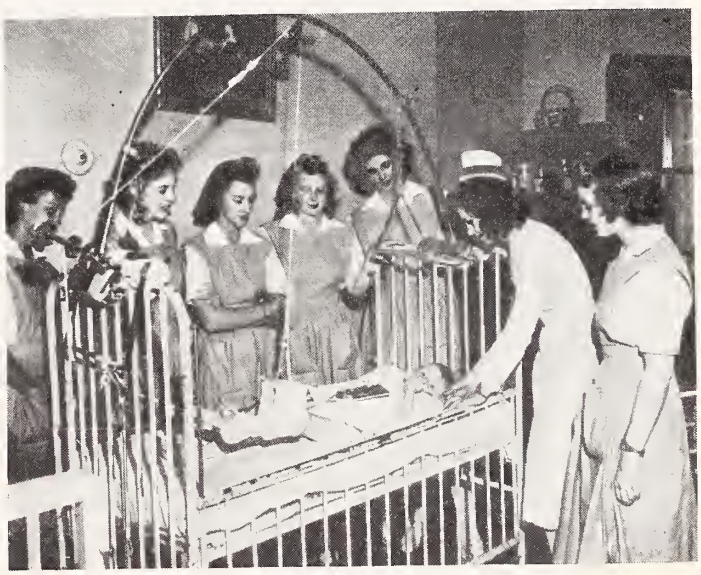
How may the home front be safeguarded? The solution lies not in discovering "ersatz" medical care nor in lowering standards but in squeezing the utmost efficiency from available resources. In this task of conserving the energy of physicians and making nursing service "go further" the American Red Cross participates actively. That is fitting for it is this organization which, by federal mandate, recruits nurses in time of war and thus helps to deplete civilian resources. With at least two activities every physician should be familiar for they have definite influence on his work. One of them is to train Volunteer Nurse's Aides, the other is to teach homemakers how to care for the sick in the home and how to provide a healthful home environment.

## VOLUNTEER NURSE'S AIDES

The idea of a Nurse's Aide Corps developed originally during World War I when many women volunteered to assist nurses in hospitals and camps at home and abroad. It languished in the peace years, but early in 1940 plans were completed for setting up a Volunteer Nurse's Aide Corps. The following year the Office of Civilian Defense designated the American Red Cross as the agency for training nurse's aides; it expanded its program and the corps is now known as the American Red Cross—Office of Civilian Defense Volunteer Nurse's Aide Corps. In 1943, the Veterans Administration and the Surgeon General of the Army directed those in command to request the services of nurse's aides when needed. Civilian hospitals have used the aides extensively and many report that operation on an efficiency level would now be impossible without the help of nurse's aides.

The aide is trained by registered professional nurses, authorized to teach by the American Red Cross Nursing Service. The course consists of 35 hours of lectures and demonstrations and 45 hours of supervised hospital practice. Tasks the aide learns to do include the following:

Take temperature, pulse, respiration.
Sit with patients recovering from an anesthetic.
Give enemas.
Prepare treatment trays for sterilization.
Help to apply plaster casts.
Assist with unsterile dressings.
Assist in emergency rooms and obstetrical departments.
Give bedside care to selected patients, in homes, under the direction of visiting nurses.

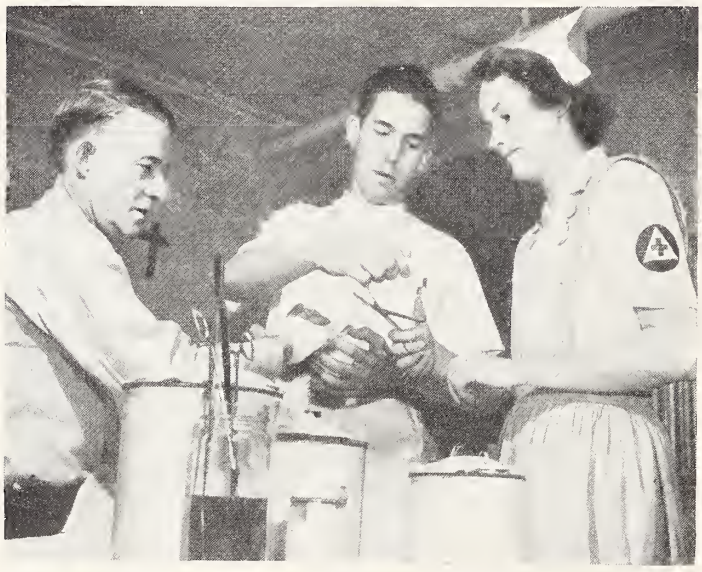


A typical group of students learning to be Nurse's Aides in a class sponsored by a Red Cross chapter

In addition, other special duties which, in the opinion of hospital authorities and the American Red Cross Nursing Service are perfectly safe for a non professional person to do, may be assigned. The aide always works under the supervision of graduate professional nurses.

While teaching emphasis is placed on what the aide *may* do she is also carefully instructed in what she *may not* do. The guiding principle is to permit those technics or services which may be learned by repetition and to prohibit those which require judgment based on scientific background and experience. A nurse's aide may not, for example, give medication of any kind, or hypodermic injections. She may not assist with sterile dressings.

In an amazingly short time nurse's aides established their value and when it became apparent that nurses were not entering military service in sufficient numbers to meet Army needs, the Army asked that aides be permitted to accept service for pay in military hospitals. At present, nurse's aides who have given 150 hours of service may apply for service in Army hospitals. If accepted, they are given Civil Service status and are paid a basic annual salary of $1,440. During the period in which she is so employed, the aide is granted a leave of absence from the corps and may resume her former volunteer status upon discontinuance of her service as a paid nurse's aide.



Nurse's Aide assisting the doctor in the emergency room

Since Pearl Harbor was attacked, about 5,226 women in Connecticut have graduated as Nurse's Aides. There are at present 33 qualified instructors in the state, and a number of classes are in session. 49 hospitals (including 5 Army hospitals), and 24 visiting nurse associations are using nurse's aides.

What effect this war emergency enterprise is likely to have on medical practice after the war is anyone's guess. Many volunteers for this service are drawn mostly from the home and they give such time as they can spare from household duties. When the emergency ceases, they will probably resign as nurse's aides but the lessons they have learned will continue to be applied to their own problems. Among the girls in business and industry who now give their spare hours to the corps, there are perhaps some who will wish to become professional nurses and still others can be given additional preparation to qualify them as trained practical nurses. Nurse's aide training is also excellent basic training for the private physician's helper or office girl.

Not lightly to be reckoned with is the effect on medical and nursing standards of the future. Some hundreds of thousands of women who have seen medical practice at close range will be more discriminatory, perhaps more demanding, than they were before. They will have had glimpses of the doctor's and nurse's problems and will wield a strong influence in the community. One hopes that what they have experienced will prompt them to support, as intelligent citizens, that which is good in medical and hospital practice and to denounce the false. They will be aware of the demands made by hospitals upon their nursing staff and of the many problems troubling nurses and management within some of these institutions. Certainly the wool will not easily be pulled over the eyes of the public spirited women who know the sight of blood, the smell of ether, the moan of suffering and the vigil of the doctor.

### HOME NURSING

Last year a half million persons in the United States completed the home nursing course. In 1908, when Mabel Boardman somewhat timorously arranged for a series of lectures to women on home care of the sick, objectors warned that such teaching of laymen would endanger nursing standards and encourage self-treatment. Medical and nursing leaders were therefore invited to help formulate a course which would be both safe and practical. The new course was at once popular and spread over the country. World War I gave it impetus. During the period of readjustment and depression, the enterprise waxed and waned. Then came the shock of Pearl Harbor and an eager demand for self help. The course was streamlined and given its new name—Red Cross Home Nursing. Since January 1, 1944, 452 classes in Connecticut have completed the course and 106 are now in session.

Home nursing is a special household skill and does not prepare persons to render public service. The



Bathing the baby is but one of the many household skills learned by the Home Nursing student

udent learns to read the clinical thermometer, cognize certain signs of illness, keep a bedside cord. She knows how to apply a hot water bag, dispose of dangerous excretions, to give an enema. he has had instruction in preparing tasty well alanced meals and can change the bedding and ove the patient without unduly disturbing him r tiring herself. Because of her training she appre- iates good medical and health service and she rives to keep the family well. The text book she udied remains at home with her—a far more reliable ference guide than the musty "doctor book" or ie patent medicine almanac.

What the home nursing student learns emphatic- ly *not* to do is to make a diagnosis, to prescribe edication, to attempt treatments which only a rained nurse should give. She does know the signifi- ance of fever, rapid pulse and various outstanding mptoms, hence she knows when to call the doctor id when to leave him undisturbed. Her knowledge, mited as it is, gives her poise. That is a great asset the home where every sign of assurance or of prehension of the homemaker flashes its message the sick person for good or ill. In these days when urses are rationed, it is a satisfaction for the doctor deal with the understanding homemaker who is ot utterly ignorant of simple procedures, who can e relied upon to carry out orders and who will aintain that serene atmosphere in the household hich springs from confidence.

The course may be taught to adults in a minimum f 24 hours within a period of four weeks. Nurses, who have qualified as instructors conduct the classes. The teaching is done primarily by actual practice—students learn to do by doing. Each technic is demonstrated by the instructor, then the student is expected to "give it back." Whenever practicable, improvised equipment is used and students are encouraged to use initiative in devising their own substitutes for sick room necessities and comforts. The course is divided into four units:

I. Health and Happiness in Home Life.

II. How the Community Protects the Health of the Home and Family.

III. How to take care of Mother and Baby.

IV. What to do When Sickness Invades the Home.

Recently a six-lesson course has been introduced for busy people, which is a break-down of Unit IV as follows:

Lesson

1. When Sickness Occurs.
2. The Patient Goes to Bed.
3. The Clean and Well Groomed Patient.
4. Food and Medicine for the Sick in the Home.
5. Simple Treatments ordered by the Doctor.
6. Summary and Review.

Two difficulties confront the Red Cross in extending this work as widely as it should be. One is the dearth of instructors. The other is lack of interest of persons who could and should take the course. An annual enrollment of 500,000, is to be sure, gratifying but not nearly enough. After all, persons must be given an incentive to enroll. In encouraging enrollment the practicing physician can be of great help. There is no glamour in the course and the certificate does not entitle one to wear a uniform, although an attractive pinafore has been designed for use in the home. A small pin may be worn. But perhaps the strongest incentive is the promise of acquiring skill. What woman's bosom does not swell with pride when she is known to have a special knack; whether it is to flavor the apple butter, hem a skirt or give an enema. Running a household, sick or well, is drudgery unless one takes pride in doing it well. "Who in this household has had home nursing?" will bring a proud response from the certificate holder. If no one has taken the course the question will prompt mother or sister or even father to enroll in the next class at the nearest Red Cross chapter.

Again, as in the case of volunteer nurse's aides, the thousands of women who have taken the Home

Nursing course, thereby develop an appreciation of scientific medicine. This enhances the doctor's skill and also puts him on his mettle. The veterinarian enjoys certain advantages over the physician—his patients never "talk back." But the wise physician prefers not merely to "do things to" his patients but rather to guide and counsel them. The better they understand, the surer will be their cooperation.

In the broad problem of fitting medical resources to social needs these women will be interested too. The time has passed when all questions involving medical practice are settled by the profession. Adjustments to this changing world will be more intelligently made with the support of people who are reasonably well informed than by those who are indifferent or influenced by quackery.

Whatever the distant effects of these training projects may be, our immediate concern is with the practical results today. The war's demand for physicians and nurses will increase. We can stop the production of autos, we can banish horse racing, but we cannot depreciate medical care of the home front without weakening the war effort. None is better qualified to develop our resources than the practicing physician. His support of the Red Cross and particularly of the Nurse's Aide program and Home Nursing classes, is a patriotic service.



A father of five weeks learns how to burp the baby in a Home Nursing Class for men

## THE POST WAR PROBLEM OF TUBERCULOSIS

Cole B. Gibson, *Meriden*

The Author. *Superintendent Undercliff Sanatorium.*

The optimism shared by many a few years ago that tuberculosis was rapidly approaching the state of a controlled disease is being shattered and dissipated by discouraging events directly connected with World War II. During the period between the World Wars the death rate was almost halved in the United States, England, the Scandinavian countries, Germany, and Austria.

In those conquered countries where real progress had been made it is now clear, even with incomplete reports, that the tuberculosis problem may be even more serious than ever. For instance, the Avenir Medical reports that tuberculosis has risen 20-30% in France, and takes malignant forms rapidly fatal especially in young people. It is not only in France but among the workers sent abroad that malnutrition and tuberculosis are rampant. "French doctors see with horror the ever increasing number of French workmen sent to Germany who return to their country to die of rapid phthisis."

In Rome, 3,450 persons died from the disease in the first half of 1943, as compared with a prewar average of 1,200. Deaths from tuberculosis in Belgium increased more than 50% after one winter of German occupation, and the number of cases of tuberculosis rose from 70,000 in December 1941 to 110,000 in February 1943. Also, in Holland, there was an indicated increase of well over 50% in the death rate during the period of the war, with an especially rapid increase in 1943.

Lord Horder, in the House of Commons, reported that "galloping consumption," which had been uncommon for two generations, is today a common

experience in Belgium, France, and Greece. Germany, too, has had a 25% increase in its tuberculosis death rate during the period from 1939 to 1942, and recent fragmentary reports indicate a continuance of the climb.

In the early days of the war, England, Scotland and Wales experienced an increase of from 7 to 10 per cent in tuberculosis deaths. This status has remained about level during the past two years; and Canada, Australia and New Zealand have maintained a rate slightly less than the immediate prewar period.

Fortunately, the United States through 1943 has been able to maintain its record of decline in the death rate, the figure for 1943 having been about 42 per 100,000 as against 47 per 100,000 in 1939. For still one more reason then the United States may give thanks that thus far its people have not been subjected to the privation and suffering that follows in the wake of the crushing, devastating machine of war. There are some who predict that our picture may yet be darkened. These point out the long continued physical strain and effort of war produciton, and the dislocations due to war time housing and nutrition may yet have a lowering effect upon resistance to tuberculosis. They point also to mass movements of certain of the worker population with the attendant crowding and greater opportunity for exposure to tuberculosis as a possible factor in an increase in the disease.

They also are aware that on June 30, 1941 there were being paid 53,589 service connected active disability awards to veterans of World War I for tuberculosis as the major disability. In addition, 10,135 World War I veterans were receiving pensions for non service connected tuberculosis, and that as of the same date, 48,330 death claims had been paid to dependents of veterans who died from the disease.

In other words, in a period of slightly under 24 years, one veteran alive or deceased of every 42 individuals who served in World War I was known to have suffered with tuberculosis of a compensable or pensionable degree.

In light of this experience with World War I, and realizing the greatly increased numbers in our armed forces in World War II, it is perhaps natural that some are apprehensive as to our control of tuberculosis in the years that lie ahead.

The problem in the devastated countries is now acute and critical. For the present, it is an additional burden to be shouldered by the United Nations in the form of providing medical, nursing, and segregation facilities to the peoples now under their control. This is, of course, in addition to the necessity of furnishing this bereft humanity with food, clothing, and shelter. Eventually, the nations, themselves, must take over and by their own endeavors meet this most difficult medical problem at the same time that they are attempting to raise their standard of living.

In the United States there are several favorable factors that may have a gratifying influence on the trend of our tuberculosis mortality. Preinduction chest x-ray examinations undoubtedly prevented large numbers of active cases of tuberculosis from entering the armed forces where they would have been a source of danger to themselves and to their comrades.

Moreover, in many instances, the disease was discovered in unsuspected individuals who had early and curable disease. Efficient follow up machinery placed the majority of these people under observation, and they received treatment much earlier than might have been the case if Selective Service had not been in operation.

In addition, vastly improved medical care in this war has brought a wider and more frequent use of the x-ray upon those actually in service, with the result that here again nascent tuberculosis is brought to light much more promptly. The organization for handling such cases is now rounding into efficient form and it should pay valuable dividends in the way of cured and arrested cases.

The problem of the tuberculosis veteran is being given profound study by some of our foremost Army, Navy, Public Health, and civilian authorities. There is good reason to anticipate that the end results of the treatment of tuberculosis veterans of this war will be better than those attained in veterans after the last war.

It is most certainly to be hoped that some method will be devised whereby the veteran with active disease may be persuaded to remain upon institutional regimen until arrest or cure has been achieved. Actually, the veterans of World War I were often encouraged to leave sanatoria or Veterans' Facilities and interrupt treatment by reason of the fact that financial benefits were greater for the patient out of the hospital than for one who remained in the institution. Very often, such patients returned to home communities with no coordination of medical information with the medical authorities of the area.

Similar instances have occurred with veterans of World War II, but the Veterans' Administration is aware of this inexcusable lapse in proper treatment; and plans are now being effected whereby systematic and prompt reports on self-discharged veterans with active tuberculosis will reach local health authorities. This is indeed a forward step. In this phase, as in others, the Veterans' Administration is developing a program that is evidence of a highly constructive attitude.

Another favorable factor is the establishment of a tuberculosis control division in the Public Health Service. The function of the new division will be:

"1. Developing and effecting means for the prevention, treatment, and control of tuberculosis.

"2. Assisting states, counties, health districts, and other political subdivisions of the states in establishing and maintainnig adequate measures for the prevention, treatment, and control of such diseases.

"3. Preventing and controlling the spread of tuberculosis in interstate traffic, and any other activities with respect to the prevention, treatment, and control of tuberculosis which may be authorized to be performed by the Public Health Service."

The sum of $10,000,000 was authorized in the act of 1944 for this new work and will be available as funds are appropriated.

Here in Connecticut, the State Tuberculosis Commission through its Department of Tuberculosis Control has already made much progress in extending the program of tuberculosis case finding and follow up work. Mass x-ray surveys in industrial plants, schools, and other organizations are being carried out in increasing tempo and on an ever wider range. Unsuspected cases of tuberculosis are being unearthed by this method; and appropriate handling of the tuberculous cases so discovered is not only contributing to arrest and cure of the disease in these people, but by recognizing and segregating them there is reduction in the community of the number of open cases of the disease which are sources of infection for the remainder of the population.

Along the lines of the planned activity of the United States Public Health Service, and quite possibly in conjunction with that Service, plans are now under way for the development of several Tuberculosis Control Centers in the state. With such centers in operation, the Tuberculosis Commission envisions an even more accentuated drive for early diagnosis, a helpful consultation service both for people suspected of tuberculosis and for the post sanatorium patient who requires follow up and observation.

It is planned that these centers will be so located as to make their service readily accessible and available to all the people of the state in what appears to be a well coordinated and concerted drive towards further reduction of tuberculosis mortality in Connecticut.

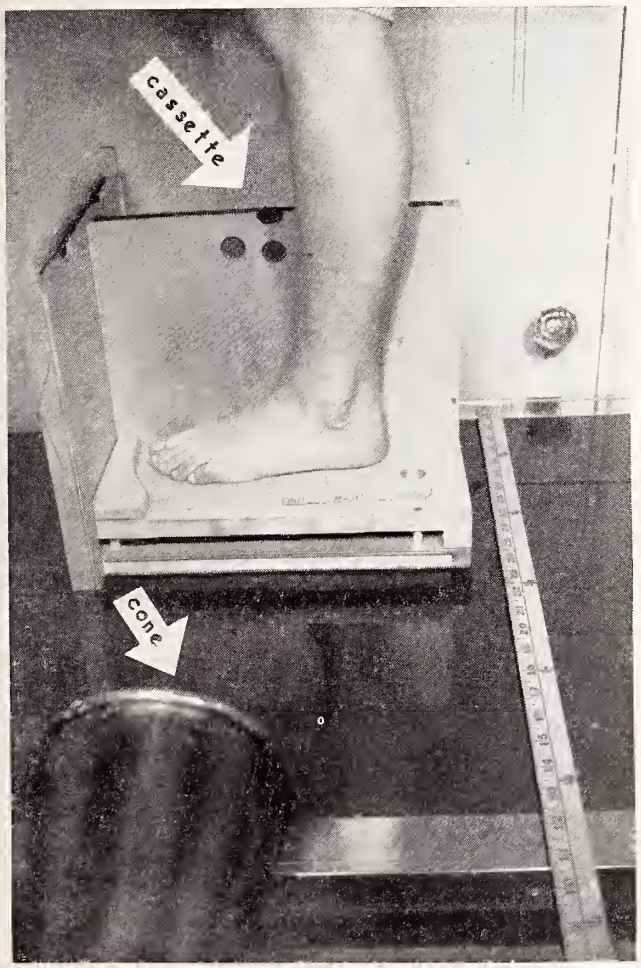
The post war problem of tuberculosis will undoubtedly be of even more than serious import in other countries, and in the United States it may be difficult and trying. However, here at home, and particularly in Connecticut, there is keen awareness of the potentialities. It would seem that the steps taken and provided for are indicative of the type of public health thinking which is essential to the control of disease, even such a scourge of mankind as tuberculosis.

# ROENTGENOGRAPHY OF FEET UNDER WEIGHT BEARING CONDITIONS

C. W. Goff, M.D., *Hartford*

The Author. *Assistant Orthopedic Surgeon, St. Francis Hospital, Hartford; Attending Orthopedic Surgeon, Newington Home for Crippled Children, Newington*

Roentgen studies of feet under functional stress and strain will lend considerable aid to the orthopedist in his analysis of foot disturbances. A simple technique is presented that has proven of great value to the author for a number of years.




Position 1—*Lateral view* of right foot and ankle. Tube distance 30 inches. Milliamperes 30. K.V. 50. Time 2 seconds. Cardboard cassette. No screen film. Cassette shown in slot.

Position 2—*Lateral view* of left foot and ankle. Same as position 1) with apparatus reversed.




Position 3—*Posterior-anterior* of both feet and ankles. Tube distance 30 inches. Milliamperes 30. K.V. 62. Time 2 seconds. Cardboard cassette. No screen film. The illustration shows heels on a two inch balsa wood block which permits visualization of metatarsals.




Position 1

Plate of Right
foot and ankle

Position 2

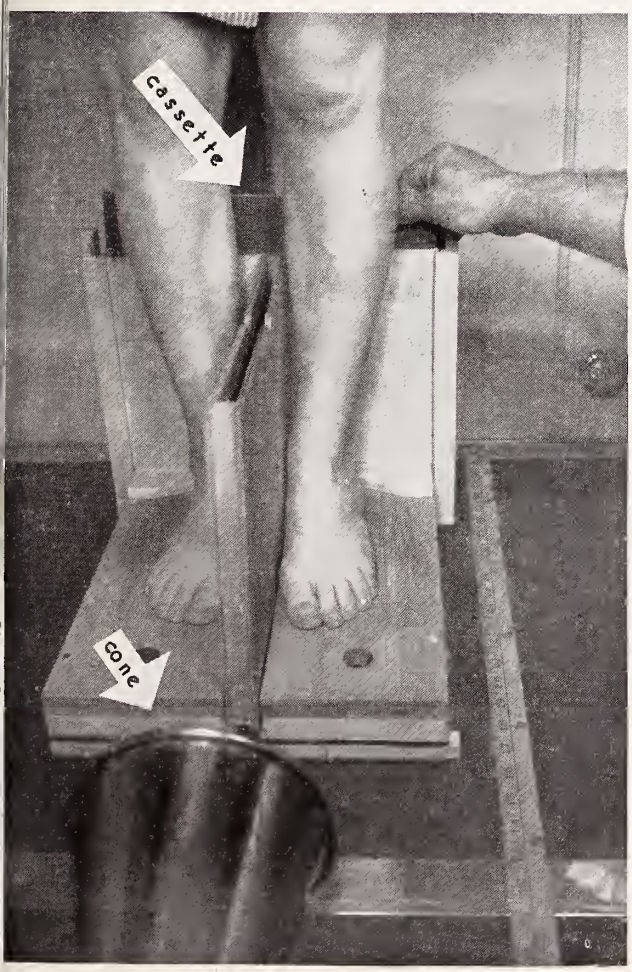
Plate of Left
foot and ankle



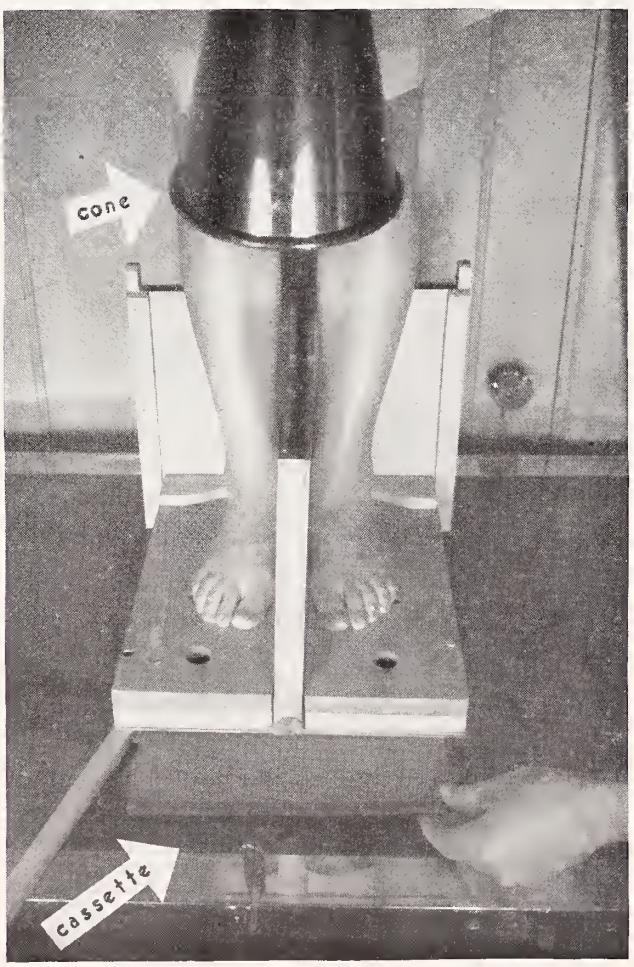


Position 3

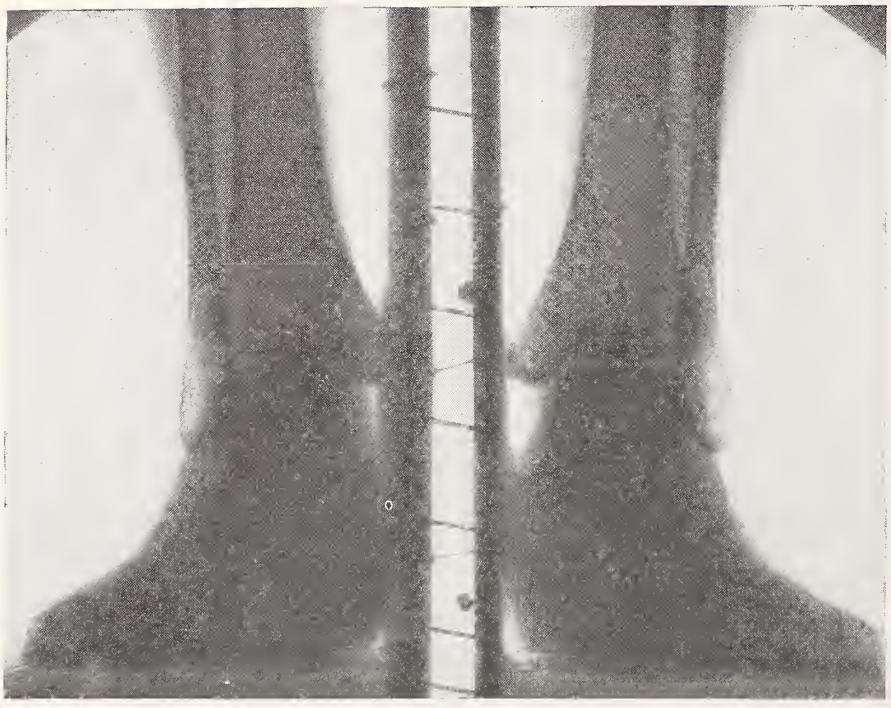
Plate showing metatarsal heads as they touch surface of weight bearing. Note absence of a metatarsal arch—observe sesamoids.




osition 4—*Anterior-posterior* of both feet and ankles. Tube istance 30 inches. Milliamperes 30. K.V. 62. Time 2 seconds. ardboard cassette. No screen film. As illustration, showing nkles together with outline of feet as a weight bearing yramid. Cassette shown as it is about to be dropped into receiving slot.



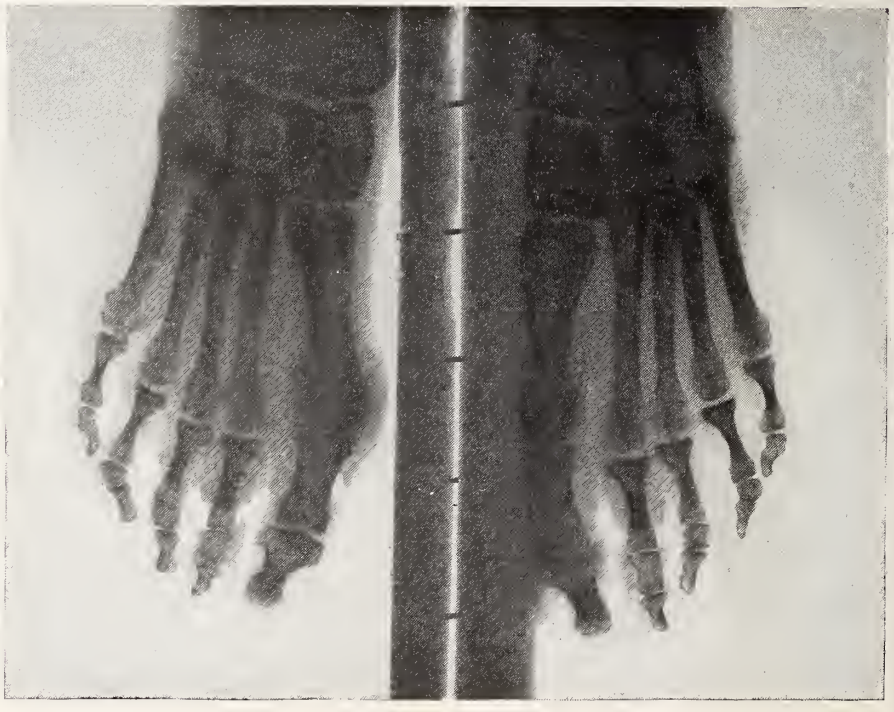

Position 5—*Plantar anterior view* of both feet. Tube distance 30 inches. Milliamperes 30. K.V. 56. Time 2 seconds. Cardboard cassette. No screen film. Tube is directed at an angle of fifteen degrees from the perpendicular. Cassette pushed home in receiving slot.

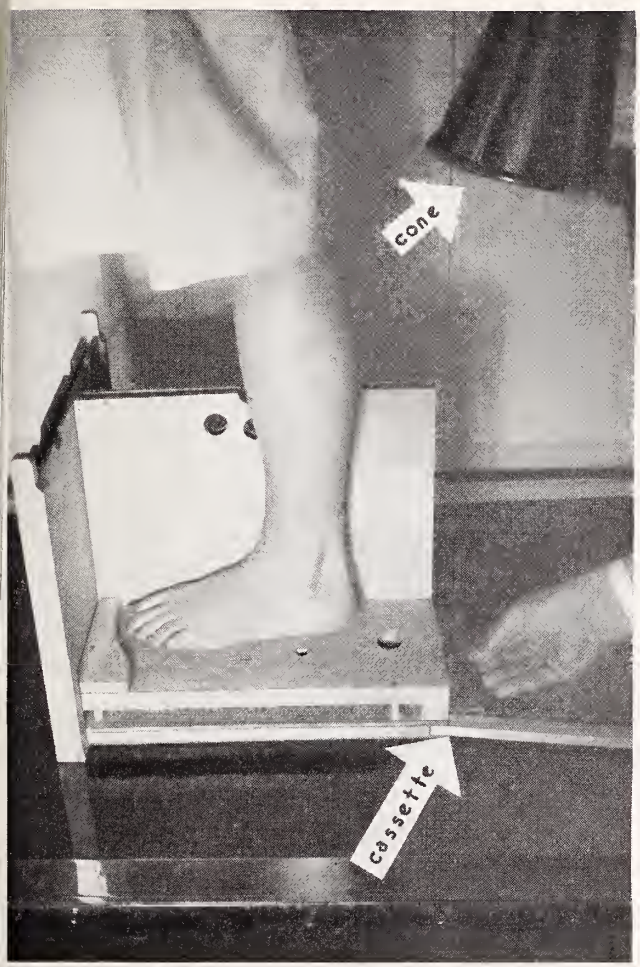


Position 4

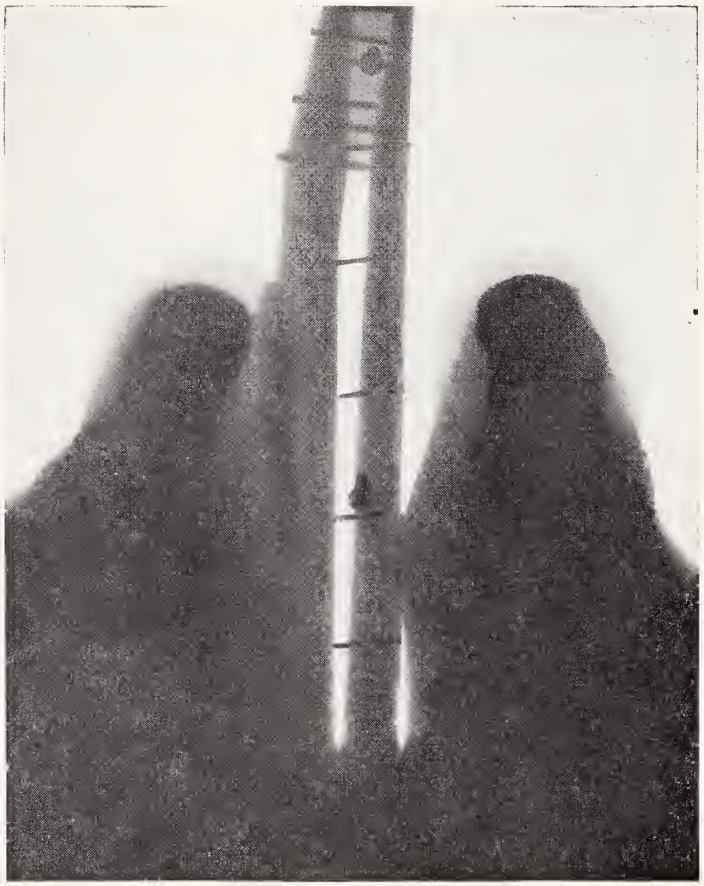
Plate shows pyramid of weight bearing

Position 5






Position 6—*Plantar posterior view.* Especially valuable for visualizing fractures of the os calcis or pronation deformities. Tube distance 30 inches. Milliamperes 30. K.V. 62. Time 2 seconds. Cardboard cassette. No screen film. Angle of tube again 15 degrees with the perpendicular.



Position 6

No dimensions are given because they can easily e taken from illustrations. An 8 x 10 cassette is ufficiently large for practical purposes. Plywood has been used throughout with maple dowels where necessary. This makes the frame sufficiently strong and the cost negligible. The apparatus is centered on any flat roentgen table and the tube easily adjusted. If preferred a G. E. portable tube can be used with apparatus on floor. The resulting studies place in the hands of an orthopedist concrete evidence of foot and ankle disturbances as they occur under weight bearing.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*



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# EDITORIAL

## Medicine in Industry

"The spirit of commerce," wrote the elder Dwight, "was brought to this country in the ship which wafted the first settlers of Plymouth over the Atlantic. Trade was opened by them with the Indians the first summer after their arrival." From that early day to our own the spirit of enterprise in the New England people has been traditional and the foundations of American Industry itself are to be found in this small corner of our vast country. In spite of legend our own commerce in Connecticut did not begin with trade in wooden nutmegs. Like our northern neighbor, we, too, were early engaged in barter with the surrounding Indians and the Dutch at New Amsterdam. Industry or manufacturing undoubtedly had its beginnings in the craftsmen in wood and iron who were among our earliest settlers. Their excellent work is still seen in fine example. The use of water power machinery in the early grist mill also represents the beginning of manufacturing in Connecticut. From those early days to the present, Industrial Connecticut has shown a development by continuous growth, at times remarkable for its celerity, sometimes shifting in its locale and even its product, but always a continuity—a growth marked by expansion into diversified fields. Within itself industry has developed many new concepts and technics which have been of advantage. One of these relatively new developments has been the application of medical science to problems associated with the workers in industry.

This expansion of medicine in industry is a development in medical practice without precedent and it is questionable whether Medicine itself is fully aware of the scope of this development or of its great opportunities. This thought occupies the minds of the editors, who welcome the opportunity in this issue to place before our readers papers dealing with certain aspects of this relatively new and important branch of medicine.

Taken in its broad sense, Industrial Medicine is Preventive Medicine and the role of the industrial physician, according to Dr. Yeager, is largely that of "a public health officer for industry." This author also points out the great value for the individual worker and to industry of the closest cooperation between the family physician and the plant physician. In the rehabilitation program, to which so much thought is now being given, the importance of placing the individual in the job for which he is best suited is very great. Dr. Brody states that even most psychoneurotics are employable if properly placed and handled. It is obvious that the parts that are to be played in the rehabilitation program of industry by the full time, part time and practising physicians are of great importance. Among the many problems with which industrial medicine has to deal are those of toxicology. Dr. Fairhall discusses many of these in his timely contribution.

Within the past month a most successful industrial health conference was held at New Haven. This was sponsored by the Manufacturers Association of Connecticut and our own Committee on Industrial Health. In subsequent issues of this JOURNAL we shall hope to publish many of the valuable papers presented at this important meeting.

The advent of medicine in industry his already accomplished something more than medical service to the worker and the saving of man hours for industry. It is a humanizing force which will accomplish a great deal to further the all necessary cooperative effort between labor and industry, upon which the future of our country so inevitably rests.

## Your Professional Liability Insurance

The recent adoption by the House of Delegates of a group plan of professional liability insurance for members of the Connecticut State Medical Society is a new development in this type of insurance. Under the new plan all Society members will be united in one group and for many of our members this means a definite saving in the cost of insurance. The details of premium rates appear elsewhere in this issue. It seems hardly necessary to remind ourselves that claimants are no respecter of persons and that from time to time even leading men in our profession have been confronted with damage suits. Such suits always place in jeopardy the defendants reputation for integrity, skill and care. To be adequately protected at such a time is a matter of plain common sense. The adoption of the new plan is an important forward step in the affairs of our Society.

## The Critical Shortage of Military Nurses

The shortage of nurses in military service, despite continuing and in recent weeks intensive emphasis on its gravity, in the press and through other channels, has reached the critical stage. The solution of this problem, for it must be solved, has become one of the most exigent and immediate obligations in the support of the war effort.

The nursing profession's record for voluntary enlistment is indeed a creditable one, unsurpassed by any other group. However, less than 60,000 of the 75,000 who sought commissions in the Nurse Corps, met the stringent requirements and some 10,000 of those assigned have since been separated from the Corps. As a result, instead of attaining the Army standard of one nurse to fifteen men in hospitals here, and one to twelve overseas, the average in the country was recently one to about twenty-two patients and some hospital units have been sent overseas without nurses. It is clear that every effort to amend this dangerous situation must be put forth without delay.

The solution requires the close cooperation of many persons and the responsibility of physicians in particular is plain. It requires first of all the enlistment of nurses who have remained on home jobs because of pressure which has made the need for services in under-staffed hospitals and other agencies seem more urgent than the appeals of recruiting authorities. A second remedial measure lies in the increased enrollment of women as Nurses Aides and in the Cadet Corps.

The relaxation by military authorities of some regulations would unquestionably be an effective step in easing the present emergency. In this connection, it has been recommended by the Nursing Council for War Service that the Navy cease to drop nurses who marry and that both services admit more Negro nurses. The hiring for home hospitals of more nurses who are unable to meet Corps requirements and the greater use of Nurses Aides and WACS is also strongly advised.

The final and perhaps the most important requisite is the cooperation of doctors and the public to relieve pressure on home front nurses. Hospital staffs should urge that nurses go, not stay, physicians and the public should forego nursing service in home and hospital wherever it is possible.

The failure to put the needs of wounded soldiers before those of civilians and to add thousands of nurses to the ranks of those now serving would be disastrous and it must not be allowed to occur.

## The Building Fund Campaign

Last month we reported the campaign for a new home for the State Medical Society off to a good start with an impetus of $6,000 in pledges and gifts from the Council and the Trustees of the Building Fund. Contributions are coming in daily from every county in the State. Although the goal of $50,000 is not yet in sight, with 115 contributors on January 15 the Trustees look for 100 per cent attainment of the desired goal.

Included in the first report of the Trustees to the House of Delegates in May will be a list of the contributors. One physician submitted the suggestion that every member be assessed a certain amount—and with this suggestion enclosed his check.

Anyone familiar with the crowded conditions existing in our State Society office and with the number of groups which meet there almost daily will realize the need for a new home. Find that pledge card you may have mislaid and send it in NOW. If you cannot find it, a post card will bring another by return mail.

## Intern Training

The report of the subcommittee of the State Post War Planning Board on Intern Curriculum is printed elsewhere in this issue. It is a careful and comprehensive study of this problem and it should be thoughtfully considered by all those who are associated with the professional and the administrative staffs of our hospitals. The success with which some of our hospitals have attracted capable graduates in medicine for intern positions is obviously not accidental. It is due to the fact that in those institutions it has been recognized that intern training is an essential part of medical education and definite programs have been established for such training.

In considering the report, we should bear in mind that it sets forth not only a present but a future useful pattern for the hospitals of Connecticut. The recommendation that certain professional services be placed on a full time basis is useful, not only to augment the intern training program but for the proper development of the hospital as an efficient unit for the care of the sick. The addition of the services of a psychiatrist to this group will be no surprise to those who have followed this interesting trend as witnessed by articles published in this JOURNAL and elsewhere.

The suggestion that a teaching coordinator to supervise intern training definitely places that responsibility where efficiency should be assured. Some of our hospitals are already carrying out a similar plan by having a member of the professional staff act in this capacity. The recognition of this need augurs well for its future development. As a source of important information and a guide for present and future development in this field of medical education, the report in intern training is a timely and important document. Its sponsors deserve our congratulations and commendations.

## "Soldier to Civilian"

Dr. George Pratt of Westport has written a thoughtful treatise on the returning soldier ("Soldier to Civilian," Whittlesey House, $2.50). He points out that most soldiers escape physical wounds, but not one of them can escape psychological trauma and even soldiers with sound emotional characteristics are likely to break under the strain of war, while men who go into the Service with emotional instability will certainly break and what Dr. Pratt has to say about their future is far from reassuring. It is clear that all of this will lay a heavy burden upon people at home when the soldier returns and particularly on his own family. It calls for an exhibition of wisdom, tolerance, patience, and humor, characteristics that all do not have.

Dr. Pratt has directed his book to family and friends rather than to the veteran himself for he feels that the answer to the problem will be found there and he wants the people at home to realize that the man who comes from the war will not be the same man who went away. It is certain that the family physician will play an important part in advising on the adjustments that will have to be made and he will be confronted with new problems and psychosomatic medicine. Our fellow member has made a fine and perhaps the first contribution to an important field of psychiatry.

## The Group Plan of Professional Liability Insurance

This announcement brings to your attention the adoption of a Connecticut State Medical Society Group Plan of Professional (Malpractice) Liability insurance protection. This Plan is available only to

members of our Society. It was unanimously approved by the House of Delegates at its meeting held December 8, 1944 after a complete survey by your Insurance Committee acting under the resolution passed at our last annual State Medical Society meeting. The Group Plan, to become effective February 1, 1945 is to be covered in the Ætna Casualty and Surety Company of Hartford, Conn. Heretofore this company has had a majority of our members insured under separate local, city and county society units. Now our members will all be united under one State Group Plan. It will embrace the entire State of Connecticut, thus bringing the Group Plan home to the members of two of our component County Medical Associations who have not heretofore had group protection available to them—a feature we know will be greatly appreciated by these members. Then, too, we believe every member will appreciate the opportunity to obtain protection at the low rate of $12.50 for basic coverage of $10,000 in any one claim and a total of $25,000 for all claims on account of professional treatment rendered during any one policy year. Some members have enjoyed this rate in the past—others have not. Now it is available to all members subscribing to the State Group Plan. Higher limits of protection can be obtained at small additional cost.

Any member now insured under an existing local Ætna Group Policy can, if he so desires, transfer to the State Group immediately, otherwise transfer will be made upon expiration of his present Ætna coverage. At that time, providing he is still a member of the Connecticut State Medical Society, he will automatically be transferred and renewed by the Ætna under the State Group Plan. However, should any member, in comparing his present rate and limits of protection with the following schedule as a guide, desire to increase his limits of protection, he can arrange to do so through his local agent and the Company will take care of each such individual request:

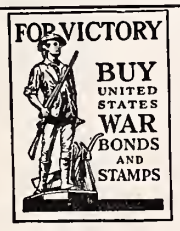
| PREMIUM | LIMITS OF COVERAGE |
|---|---|
| $12.50 | $10,000/25,000 |
| 16.75 | 15,000/25,000 |
| 17.00 | 15,000/30,000 |
| 18.13 | 20,000/40,000 |
| 19.13 | 25,000/50,000 |
| 19.75 | 25,000/75,000 |
| 19.88 | 30,000/60,000 |
| 22.25 | 50,000/100,000 |
| 24.00 | 75,000/150,000 |

Higher limits also available

A vitally important matter, which every practicing physician should seriously consider, is the carrying of adequate limits of financial protection. Your attention is especially directed to the Statute passed by our State Legislature in Connecticut establishing a $15,000 limit in damages involving death. We cite, for example, a recent death case where one of our members was sued for $15,000, with only a $10,000 limit of protection. Adequate financial protection may some day hold you in good stead against a heavy financial loss which could seriously impair your estate.

If any member of the Society is not now carrying Professional Liability Insurance, such member should take advantage of the opportunity to come in under our State Group Plan. Under this Plan you have available the services of experienced defense attorneys. Legal costs for defense alone can run into thousands of dollars. Such legal cost is paid in addition to the limits of financial protection afforded by your group policy.

The present trend in malpractice suits, as in other types of damage suits, is toward larger awards when verdicts for the plaintiff are rendered. As the number of malpractice suits increases the chance of plaintiff's verdicts also increases because physicians are being held to more and more responsibility in the treatment of their patients. Thus the legal hazard of the practice of medicine is increasing and not diminishing.




YOURS FOR THE BASKING — Our complete rental service includes various types of sun lamps available to your patients on prescription. Everyone who needs the tonic benefits of ultra-violet these busy "all out" days, cannot spare the time to bask on the beach, but details on PROFESSIONAL summer sun for everyone, for convenient bedroom use, is yours for the asking. Professional Equipment Co., New Haven.




(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 Church Street New Haven

## JANUARY COUNCIL MEETING

The regular monthly meeting of the Council was held at the office of the Society at 4:00 o'clock Friday, January 5. There were present: James R. Miller, Chairman, H. Gildersleeve Jarvis, Samuel Mullins, Arthur B. Landry, Charles Russman, Herbert Thoms, George H. Gildersleeve, Robert C. Pair Thomas P. Murdock, Stanley B. Weld and Creighton Barker. Absent: Joseph H. Howard, Hugh B. Cam bell, Floyd A. Weed and Charles T. LaMoure.

## RESOLUTION FROM THE SECTION ON RADIOLOGY

After considering the following resolution received from the Section on Radiology, it was voted that t Chairman of the Council appoint a committee from the Council to confer with the Trustees of the Co necticut Hospital Association on the subject of hospitals billing, collecting and paying for professior fees such as radiology and anesthesiology.

The Connecticut State Medical Society has unanimously affirmed that the inclusion of professional medical fees in Hospital Service Insurance contracts is unsound and detrimental to the best interests of medical practice, and that service benefits in Blue Cross Plans should be confined to hospital service. In order to facilitate a practical application of this action in radiological practice, the Radiological Section of the Connecticut State Medical Society recommends that the single x-ray charge now made to private and semi-private patients in hospitals should be separated into a hospital charge for technical service and a professional fee and believe that such a step would benefit the patient, the hospital and the radiologist by:

1. Preserving the private practice of radiology in the hospital regardless of whether the radiologist is full time in the hospital or has a private practice outside the hospital.

2. Placing the control of professional charges in the hands of the radiologists so that consideration can be given to individual circumstances.

3. Preventing the hospital and radiologist from exploiting one another.

4. Tending to reduce the cost of x-ray examinations.

5. Making the patient aware that a physician is being paid for interpreting his films.

6. Giving a clear understanding of how charges are computed, and if charges are excessive, whe that excess originates.

7. Placing the private practice of radiology in tl hospital on a similar basis to that of other physician

The Radiological Section of the Connecticut Sta Medical Society urges therefore that the Counc approve the following principles and requests th they be considered in conference with the Board Trustees of the Connecticut Hospital Associatio and adopted by the hospitals of Connecticut as guide in their relationship with the radiologists:

1. That the practice of radiology is a part of th practice of medicine, and in hospital practice th radiologist should have the same status as chiefs other services.

2. That when a single charge is made by a hosp tal to a private or semi-private patient for radiolog cal service, it be recognized that a portion of tha charge represents a fee for professional service an that it is desirable that the professional fee be sepa ated from the charges for hospital service.

3. That hospitals should make a charge for techn cal radiological service based upon actual expens plus a reasonable return on invested capital and fo overhead and replacement, but that the Radiologic Department should not be looked upon as a sourc of extraordinary profit to the hospital.

4. That control of professional radiological fe should be the jurisdiction of the radiologist and tha

a separate charge for radiotherapy, consultation, interpretation of films, and supervision of technical service should be billed and collected from the patient.

It is essential, as at present, that all x-ray examinations in hospitals have the status of a consultation and a written report made by a qualified radiologist. The hospital charge must be limited to a mutually agreed upon schedule of rates. The professional fee likewise must be based upon a submitted schedule of rates and if the intended purpose is attained, the sum of the two rates should be less, and in any event no greater, than the single x-ray fee now in general use throughout the State.

Although it is realized as traditional, that the physician should bill and collect from the patient for his services, this method may not always be practical in connection with fees of radiologists serving in hospitals and may be confusing to the patient. It is believed, however, that if fees for professional services be clearly separated from charges for hospital services on bills rendered by hospitals, the desired objective would be accomplished.

Ralph T. Ogden, *Chairman*
Berkley M. Parmelee Lawrence A. Mucci
Samuel M. Atkins Hugh M. Wilson
*Committee on Hospital-Radiologists Relations*

## Technical Medical Advisory Committee of the Office of the Commissioner of Welfare

The following recommendations presented by the Technical Medical Advisory Committee of the Office of the State Commissioner of Welfare were approved.

RECOMMENDATIONS MADE BY THE TECHNICAL MEDICAL ADVISORY COMMITTEE OF THE OFFICE OF COMMISSIONER OF WELFARE AND APPROVED BY THE GENERAL MEDICAL ADVISORY COMMITTEE OF THE OFFICE OF COMMISSIONER OF WELFARE

1. That the Office of Commissioner of Welfare use clinics and dispensaries that are supported by voluntary agencies and by taxes from Federal, state or local governments. The use of these clinics will depend on the willingness of the community or agency in charge, capacity of the clinic to take patients, and the existing facilities for treatment.

2. That special medical services, for example, simple surgical procedures, setting of simple fractures, emergency x-rays for fractures, basal metabolism tests, electrocardiograms, emergency obstetrical care, etc., be performed in the home or office. Cases that require a series of x-rays, more complex diagnostic services, or involve medical care should be referred to state-aided hospitals.

3. That vaginal examinations for children admitted to foster homes and child-caring institutions be continued.

4. That a charge of $5 be permitted for the initial examination of children for placement in a foster home. This examination should include a physical examination, nose and throat cultures, vaginal smears, serological tests for syphilis, and a tuberculin test.

5. That a mileage rate of 5 cents a mile be permitted for doctors traveling a considerable distance in order to see beneficiaries of the Office of Commissioner of Welfare.

6. That charges for dispensing of medications by the doctor be discouraged at the time a house or office call is made. Cases in which the doctor presents charges for medication should be reviewed on an individual basis by the Medical Advisor and paid if the charge is merited.

7. That a $5 charge for sigmoidoscopic examination be added to the Medical Cost Standard.

8. That there be no extra charge by the physicians for parenteral injections. An exception to this is the injection of hormones, and in these cases an extra charge of $1 may be permitted or the medication may be purchased by doctor or patient and charged to the Office of Commissioner of Welfare.

9. That there be no extra charge above the office visit charge for diathermy treatments, short wave, infra-red, ultra-violet, etc.

10. That surgical, orthopedic, or prosthetic devices be obtained only on the recommendation of a physician.

## American Cancer Society Fund-Raising Campaign

It was voted to approve the participation of the Connecticut Branch of the American Cancer Society in the forthcoming campaign to raise $5,000,000 by the American Cancer Society.

## United Medical Service of New York

It was voted to approve the request of the United Medical Service of New York City to solicit partici-

pation of Connecticut physicians in the operation of a prepaid medical service plan of the United Medical Service of New York City.

## By-Law Revision

The revision of the By-Laws that had been submitted by the Special Committee on By-Law Revision, under the chairmanship of William Mac Shepard, was referred to a subcommittee of the Council consisting of Arthur B. Landry, Chairman, Herbert Thoms and George H. Gildersleeve for the purpose of reviewing the recommendations made by the special committee. The subcommittee of the Council is to report its recommendations to the Council at the March meeting.

## Committee On Invested Funds

It was voted that the Chairman of the Council appoint a subcommittee from the Council to review the method of handling and control of the Society's invested funds. The Chairman of the Council appointed Dr. Jarvis, Dr. Landry, Dr. Campbell and the Chairman of the Council.

## Committee Meetings

The executive committee of the Committee on Tumor Study met for its monthly meeting at the New Haven Hospital on January 9.

The Committee on Medical Care and Health of the Post War Planning Board met in Hartford for the first monthly meeting on January 10.

The Committee on Industrial Health met in New Haven for its monthly meeting on January 17.

A special meeting of the Section on Dermatology was held at the Society's office on Tuesday, January 16, for the purpose of discussing proposed legislation relative to dermatological treatments by unlicensed persons.

The Medical Advisory Committee of the Rehabilitation Service of the State Department of Education met at the Norwich Inn on January 22.

The Society's War Participation Committee, under the chairmanship of Ralph McDonnell of New Haven, met on January 24 and outlined plans for the collection of biographical data on members of the Society serving in the Armed Forces. Lt. Cmdr. William E. Neff, MC–USNR, and Major Charles C. Verstandig, MC–AUS, were invited to meet with the committee.

## Post War Plans of State University

Plans for post war development at the University of Connecticut in which the institution will attempt to fill the educational demands of returning war veterans and displaced war workers are included in a 30 page booklet signed by the trustees and released recently.

"For many years," the foreword of the booklet says, "this university has been unable to meet the demands for education from qualified citizens of the state. Each year the high schools of Connecticut graduate about 14,000 students and in normal times we are under necessity of denying entrance to more young men and women than we can accept.

"After the war, we will face a problem much greater than ever before. Added to the annual demands from new high school graduating classes will be returning war veterans whose education was interruped by the war and an undetermined number of young men and women who have been employed in defense industries, many of whom will turn to further education to fit them for life in a postwar world. It will not be possible for the University of Connecticut to meet this problem in full but much thought must be given to an effort to use its facilities present and future to the greatest effectiveness.

### PLANT EXPANSION

It is recommended that the state approve the completion of the university plant costing $7,000,000 of which approximately $1,650,000 is now available and approximately $2,890,000 to be made available through the issuance of self liquidating bonds, leaving approximately $3,000,000 to be provided by the state or as part of a possible federal post war building program.

Citing the need for education of veterans and war workers for peace time occupations, the booklet states, "job and job training are the least reward America can offer its returning veterans, the minimum recognition it can give those who have stood faithfully, loyally on the home front producing fabulous quantities of materials for the fighting fronts."

The trustees have authorized a new service to veterans, industrial workers and to general students who wish specialized semi professional or technical training on a post secondary school level. This service is embodied in the institute of general and applied arts and sciences.

The university also plans to go further in meeting the needs of adults. "A state university should be equipped for the continuing education of adults who are exercising leadership or are in a position to exercise it," the booklet states, suggesting that representatives of several professional and adult groups could come once a year for a short course of ten days or more to learn and discuss developments and contributions in their respective field. New buildings at the university should be available for such purposes.

## The Cancer Program in Connecticut

The Connecticut Cancer Society, which until recently was known as the Connecticut Branch of the American Society for the Control of Cancer and the Women's Field Army, has for a number of years contributed materially to the advancement of the cancer program in the state. The activities of the local organization, in line with the policy of the national society, have been concentrated mainly in the field of education of the public on the nature of cancer symptoms and the importance of early diagnosis and prompt, adequate treatment in the control of the disease.

From its inception, the Connecticut Cancer Society has worked with the major agencies concerned with the control of cancer in Connecticut, viz., the Division of Cancer Research of the State Department of Health, the Committee on Tumor Study of the State Medical Society and the Association of Connecticut Tumor Clinics. Each organization was represented on the directing boards of the others and the resulting association was an effective one, particularly in the developmental stages of a statewide cancer program.

Midway in 1944, after some ten years of operation on the basis outlined, it appeared that some advantages might accrue from certain modifications in organization. The proposed changes, which were directed towards the elimination of overlapping function and duplication of effort, were submitted to the participating groups and were adopted with their approval. At the present writing, the four units sharing the major responsibility for the cancer control program are autonomous organizations with functions which may be briefly summarized as follows:

COMMITTEE ON TUMOR STUDY OF THE CONNECTICUT STATE MEDICAL SOCIETY

To sponsor a state cancer control program and to correlate the activities of the organizations engaged in this program by serving as an advisory board of the State Medical Society.

ASSOCIATION OF CONNECTICUT TUMOR CLINICS

To promote advancement in the diagnosis, treatment and care of cancer patients in Connecticut by a closer relationship between the tumor clinics of the State.

DIVISION OF CANCER RESEARCH, STATE DEPARTMENT OF HEALTH

To record and analyze cancer hospital and clinic records and to disseminate to the medical profession and to the public information on cancer morbidity and mortality.

CONNECTICUT CANCER SOCIETY

To further the education of the public regarding the nature and control of cancer and to support the state cancer program.

Integration of the activities of these groups is attained through a system of interlocking directorships so arranged that each organization is automatically apprised by its delegate of projects or changes in policy, operation or administration contemplated by any one of the other organizations. The unifying influence of this system is exemplified in the plan for the expenditure of a grant from the Anna Fuller Fund to the Committee on Tumor Study. In allowing the grant, the Trustees of the Fund stipulated that it be administered by the Chairman of the Tumor Committee for work in the field of cancer prevention. It has been determined to expend this bequest in a manner that will benefit all four organizations.

In view of the correlation of the various phases of the cancer control program in Connecticut, it is inevitable that each group be deeply interested in the new undertaking which is now under consideration by the Connecticut Cancer Society. The American Cancer Society has proposed to its state branches that they cooperate in a national campaign to raise $5,000,000 by public subscription. Eric Johnston, president of the United States Chamber of Commerce, will serve as campaign director and the drive for collection of funds will begin April 1, 1945. In requesting the assistance of component state cancer organizations, the national society explains that the decision to enter the field of public fund raising was motivated by the conviction that there is an urgent and immediate need for additional monies for cancer research and for public education.

Authority to evaluate and approve research projects and to allow grants to finance all projects will be vested in the Research Committee of the Board of Directors of the American Cancer Society. The members of the Research Committee of the Board of Directors are C. C. Little, SC.D.; Col. C. P. Rhoads, MC—AUS; Florence Sabin, M.D.; James B. Murphy, M.D.; and Charles Huggins, M.D. This committee will be advised and assisted by a Board of Scientific Advisors, comprised by leaders in various fields of cancer research who will also act as chairmen of subcommittees in these fields.

An agreement relative to the division of funds raised in Connecticut has been reached by the American Cancer Society and the Connecticut Cancer Society. According to the terms of this agreement, the 1945 quota for the state is $100,000 of which $17,500, the amount of the 1944 quota, will automatically be retained in the state. Fifty per cent of funds over $17,500 up to $100,000 will also remain in Connecticut and the balance will go to the national organization.

In considering the advisability of participation in the campaign by the Connecticut branch, the question was raised of the actual need for further funds for cancer research. It was pointed out that appreciable portions of the funds held by the several Cancer Foundations have not been expended because competent research workers are not at present available. In view of this circumstance, the Board of Trustees of the Connecticut Cancer Society gave careful thought to the practicability of seeking additional funds and of supporting the drive. At its meeting on December 14, 1944 the Board of Trustees voted to cooperate in the national campaign through the contribution of its facilities and personnel, provided that the Council of the State Medical Society approve the program and statement of policy of the American Cancer Society and the proposed division of funds raised in Connecticut.

The approval of the Council for the project has been obtained and the Connecticut Cancer Society, with the support of the state's cancer organizations, is to launch in April a public drive for $100,000.

## Hospitals Approved for Graduate Training in Surgery

The American College of Surgeons announces that 231 hospitals in the United States and Canada have been approved for Graduate Training in general surgery and the surgical specialties. The list of approved hospitals for this purpose is published in the annual Approval Number of the Bulletin of the College just issued. As a result of the 1944 survey, nine additions to the approved list were made compared with last year.

In announcing the new approved list, Dr. Malcolm T. MacEachern, associate director, states that 500 or more surveys of hospitals offering opportunities for graduate training in surgery are planned during the coming year, the increased emphasis upon this work being stimulated by the need for providing ample opportunities for resumption of training by medical officers when they return from service with the Armed Forces. The college, through Major General Charles R. Reynolds, consultant in graduate training in surgery, Dr. George H. Miller, director of educational activities, Dr. Paul S. Ferguson, director of surveys, and a field staff, helps hospitals to organize graduate training programs to meet the requirements for approval, and also plans to aid physicians returning from service in resuming their training in surgery.

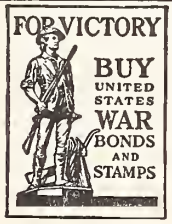
CONNECTICUT—NEW HAVEN

Grace Hospital—230—General surgery.

New Haven Hospital—537—General surgery, orthopedic surgery, urology, obstetrics and gynecology, otolaryngology.

## Birthday Dinner for Charles J. Bartlett

More than 75 friends of Charles J. Bartlett celebrated his eightieth birthday with him on December 18 at dinner at the New Haven Medical Association. Dr. Bartlett is the emeritus professor of pathology at the Yale School of Medicine, has for many years been the president of the Connecticut Medical Ex-




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

amining Board and the pathologist and director of laboratories at Grace Hospital.

David Lyman served as toastmaster at the dinner and the speakers included H. Gildersleeve Jarvis, the president of the Connecticut State Medical Society, Thomas P. Murdock of the Connecticut Medical Examining Board, Joseph I. Linde, health officer for the City of New Haven, and Marvin M. Scarbrough, president of the New Haven Medical Association.

The Cabinet of the New Haven Medical Association were hosts for the occasion and the committee on arrangements was Charles J. Foote, Ralph W. Nichols, Thomas H. Russell, Charles E. Sanford and Creighton Barker.

## Dr. R. H. Guthrie Named Head of Norwich State Hospital

Dr. R. Henry Guthrie, first assistant at St. Elizabeth Hospital, Washington, D. C., has been appointed new superintendent at the Norwich State Hospital as of January 1. He succeeds the late Dr. William A. Bryan. Dr. Roy L. Leak, acting superintendent, has left the institution and Dr. Louis Cohen becomes director of medicine and education, and Dr. Charles Clark assistant superintendent.

Dr. Guthrie appointed at a recent meeting of trustees here has been at the Washington hospital since 1939, after serving four years as chief executive officer of the Boston Psychiatric Hospital, and before that as assistant to the commissioner of the Massachusetts Department of Mental Diseases.

A graduate of the University of Arkansas, who received his medical degree in 1921 from the University of Tennessee, Dr. Guthrie interned at a special hospital for nervous diseases at Little Rock, Ark., for three years. He then became assistant physician at the Massilon State Hospital in Ohio for two years, and for the next two years was medical officer at the Boston Psychopathic Hospital. From 1929 to 1935, Dr. Guthrie was assistant superintendent of the Monson State Hospital in Massachusetts, and then became assistant to the commissioner of the Massachusetts Department of Mental Diseases.

## Major Bishop Is Awarded Bronze Medal

The Bronze Star Medal has been awarded to Major Courtney C. Bishop, formerly of New Haven, for the performance of meritorious service as a surgeon in connection with the military operations in the South Pacific area from November 23, 1942 to October 1, 1944 according to word received here.

According to the citation accompanying the award, Major Bishop, as chief of the general surgery section and subsequently as hospital inspector and executive officer, displayed outstanding devotion to duty, exceptional ability, and versatility. He carried the responsibility of organization, administration, and clinical supervision of a professional service which provided superior surgical treatment for 1,457 patients in a period of nine months.

The citation further states that Major Bishop's precise operative technique, consummate surgical skill, and sound clinical judgment enabled him to achieve a very low operative mortality. His unselfish and unremitting efforts in behalf of each patient served as an inspiration for all who worked with him.

Major Bishop entered the Army in July, 1942 and after being stationed at Fort Meade, Md., and Camp Edwards, he left for overseas duty, arriving in the South Pacific in November of that year. He was graduated from the Yale Medical School in 1930, at which time he received the Parker Prize for showing best qualifications for a successful practitioner of any man in the fourth year class.

## New Executive Officer for New York State Society

The Medical Society of the State of New York has secured the services of Robert Roger Hannon, PH.C., B.S., as its new executive officer. He succeeds Joseph S. Lawrence, M.D., now with the Council on Medical Service and Public Relations of the American Medical Association in Washington, D. C. Dr. Hannon brings to the executive office of the New York State Society not only exceptionally varied medical training but also the dignity of a wide experience both in medicine and in the New York State Department of Education.

## Hartford Hospital Presents Service Pins

On December 29, 1944 the Hartford Hospital presented 212 service pins to employees of the institution. The pins were awarded by Dr. Wilmar M. Allen, director, and were on the basis of five, ten, fifteen, twenty-five and thirty-five years of service. James H. Hamilton, director of the New Haven Hospital, addressed the gathering of about 600 people on "The Hospital's Place in the Community."

## Massachusetts Court Outlaws Middlesex School

It is reported that Superior Judge Charles C. Cabot upheld a ruling of the Massachusetts Approving Authority for Colleges and Medical Schools that graduates of Middlesex University could not qualify to take State board examinations to practice medicine.

"My decision," Judge Cabot said, "is primarily based on a comparison of this school with other medical schools concerning which evidence was produced. These were primarily the Medical Schools of Boston University, Harvard and Tufts College."

He said that Middlesex School did not have "adequate financial backing;" that that "quantity of its faculty is not sufficient," and that "the most serious deficiency of all is its almost complete lack of clinical facilities for teaching."

Graduates of the Middlesex Medical School are not eligible for admission to licensing examinations in Connecticut.

## Hugh P. Bierne's Career Comes To An End

On December 26, 1944 Hugh P. Bierne, secretary-treasurer of the State Commissioners of Pharmacy, died suddenly at his home in New Haven. His career had been a colorful one. Beginning as an errand boy in local drug stores and later as an assistant to the apothecary in compounding prescriptions, he became keenly interested in pharmacy and in 1941 was elected to head the national organization.

In 1914 Hugh Bierne organized the New Haven Drug Clerk Association and succeeded in improving working conditions for the clerks. After he became owner of his own drug store he reorganized the New Haven Druggists' Association and was elected president in 1926. His work here led to his election a few years later as president of the Connecticut Pharmaceutical Association.

He was named president of the New Haven Board of Charities in 1918 and served until 1925. In 1931, Governor Wilbur L. Cross appointed him to the state position of commissioner of pharmacy and he was later made secretary and inspector-in-chief. He has been reappointed regularly for five year terms since that time by succeeding governors. He was made a member of the executive committee of the National Association of Retail Druggists in 1935, became chairman of the board in 1939, and was unanimously elected president of the association two years later. He served for many years as trustee of the Connecticut College of Pharmacy, now the University of Connecticut College of Pharmacy, and in 1940 the college granted him the degree of honorary doctor of pharmacy.

Dr. Bierne was a valued friend of organized medicine in this state. His council was often sought in controversial problems involving pharmacy and medicine and his presence at the meetings of the joint conference committee of the two state organizations gave valuable assistance in the deliberations of the committee. Hugh Bierne will be missed by a host of friends.

## The New York State Society Loses Its Secretary

After an illness of several months Peter Irving, secretary and general manager of the Medical Society of the State of New York, died in December 1944 at the age of sixty-six. Dr. Irving was responsible for much of the impetus given voluntary health insurance in New York State. He was a member of the famous Moreland Act Commission appointed by Governor Dewey in 1943 to formulate a long range program for the improvement of the State's mental hygiene hospitals. That same year Dr. Irving served as a member of a health panel set-up to assist the OPA in New York City in disposing of requests for supplemental food rations.

Dr. Irving's training as a physician was an excellent one. He had the degree of A.B. from Columbia University and of M.D. from its College of Physicians and Surgeons. He came to the State Medical Society after many years of general practice, followed by a term as assistant secretary of the Medical Society of the County of New York. At the time of his death he was consulting physician at several New York hospitals, a member of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

The death of Peter Irving comes as a shock to his many friends. Although his health had not been good in recent months, it was hoped it might not be too late for him to carry on in a less strenuous fashion and continue to lend his friendly spirit and congenial company to many a gathering of medical comrades. It will be difficult to reconcile his absence from the group of earnest workers who have had at heart the welfare of the physicians of New York State.

# THE PROBLEM OF MEDICAL CARE

## Statement by Chairman of A. M. A. Council on Medical Service and Public Relations

The objective of the medical profession of this country is the provision of good medical care to every person in the United States. The Council on Medical Service and Public Relations intends to promote this objective. Solution of the problem of providing medical care of good quality is not simple because of varying conditions in different communities, particularly economic and environmental conditions which, while not generally considered health problems, have a marked effect upon the health of persons concerned. Eradication of conditions contributing to poor health in a community requires joint action by the medical profession and other public spirited persons.

In providing good medical care to the entire nation three phases of the problem must be solved.

(1) Adequate trained professional personnel and facilities for providing preventive, diagnostic, and treatment services must be made available to all areas;

(2) Sound economic arrangements for financing these services and facilities must be set up; and

(3) Educational efforts will be required to inform the people of the value of good medical care in order to induce them to make intelligent use of the services and facilities made available.

Members of our Council believe that the platform of the American Medical Association contains the fundamental principles upon which a sound, progressive plan for providing good medical care to the nation may be established. Accomplishment of this objective will require the sincere cooperation of the medical and allied professions, government, industry, labor, and many other interested groups and individuals.

Solution of this problem does not and will not require compulsion. The medical profession is now and has been agreed for years upon definite principles of a constructive nature, which if accepted by others concerned in this matter, will lead to a satisfactory solution of the problem upon a voluntary basis. Unfortunately these principles embodied in the platform of the American Medical Association are apparently not known to a great many people outside the medical profession. It is one of the functions of the Council on Medical Service and Public Relations to make these principles and their implications known to the medical profession, interested citizens, and public servants.

As all physicians know, the medical profession has advocated for nearly seventy years the establishment of a federal department of health under which all medical and health functions of the national government, exclusive of those of the army and navy, may be coordinated and administered. Surely it is time to simplify and coordinate all these activities under one head and a commission of competent and well qualified medical men. The medical profession seeks and will welcome an opportunity to cooperate and coordinate its efforts with such an agency, so that the present chaos may be abolished and constructive, cooperative and coordinated efforts of all concerned may be directed to a proper solution of the problems of medical care.

Reasonable agreement can surely be reached upon other planks of the American Medical Association.

"A. In the extension of medical services to all people, the utmost utilization of qualified medical and hospital facilities already established.

"B. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability, including the development and extension of voluntary hospital insurance and voluntary medical insurance.

"C. Expansion of public health and medical services consistent with the American system of democracy.

"D. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

"E. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

"F. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

"G. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration."

Certainly voluntary methods of insurance, utilization of existing facilities as far as possible, preservation of private practice, expansion of public health services, aid to the indigent or impoverished communities, and the principle of local determination of need and local control of administration are basic principles of Americanism. These things American physicians are agreed upon. Is it not poor judgment to ignore or attempt to circumvent this well considered and thoroughly studied set of principles which are the expression of a public spirited profession devoted to human welfare?

Understanding of these principles by the public and our lawmakers will pave the way for enthusiastic cooperation of the medical profession and other responsible groups in solving the problem of provision of good medical care to all.

## Prepaid Medical Care Plans

HERBERT H. BAUCKUS, M.D., *President*
*Medical Society of the State of New York*

Based on the experience of the Western New York Medical Plan, whose progress I have watched since its inception, I have reached certain conclusions about what features a medical prepayment insurance plan should have.

I believe that the best plan consists of surgical and obstetrical coverage with a "rider" providing for medical care for those who want it and are willing to pay the added cost. All of this should be on the indemnity principle.

It has not been found practical to have a clause calling for co-insurance or deductible qualifications. The Western New York Plan found that requiring a patient to pay for the first call did not reduce unnecessary calls after the first few calls. Furthermore, such stipulations are a hindrance to good medicine and to preventive care.

There should be no wage ceiling for those wishing to subscribe to a plan. Medical insurance should be regarded as by no means complete protection but as a contribution to the cost. If it covers most of the cost, it has made an important contribution. Without a ceiling, there is no class discrimination and all get the same service. This is the policy in the sale of voluntary hospital insurance plans.

It is impossible to enforce the requirement of a wage ceiling. In practice no real investigation is made, and if an investigation is made the patient will resent what he considers an intrusion into his private affairs. Often, too, the physician feels that the patient is earning above the ceiling and that he ought to pay more. The result is that any ceiling breeds distrust on the part of both the doctor and the patient.

When there is no wage ceiling requirement, the insurance element changes the physician-patient relationship very little. Since the plan is understood to be merely a contribution to indemnify the patient, there is less objection than is the case when the physician informs him that owing to his being above a certain income status, the charge will be the regular fee instead of the lower rate set up for those in the lower income brackets.

It is generally conceded that the fee schedule for the low income group should be that of the Workmen's Compensation Schedule. Few doctors would think of charging more than the rates on this schedule to a person earning $2,000. The physician is in the best possible position to know what the patient is really able to pay. It is best neither to take from him his right to fix the fee nor his obligation to make it reasonable. When he is visited by a person well able to pay his full fee, he should let him know before the services are rendered that the insurance coverage will not compensate him in full. Complete service plans mean eventually that the physician will receive substandard pay and in the end substandard service will result.

The indemnity contract has written in it the schedule of fees to be paid the doctor by the insurance plan. The bill for the entire service is sent by the physician to the offices of the indemnity plan and the part of the fee which has been stipulated is paid to the physician. If there is a charge additional to this, the executives of the plan notify the patient of this fact. This operates as a check.

Limitations, such as for pre-existing diseases, must, of course, be made in the contracts. One form of good contract gives unlimited surgical and medical care in the hospital, within range of the Workmen's Compensation Schedule, with an allowance of $50 for obstetrics, the balance to be paid by the subscribers. (This does not provide for specialists' services.) Most plans make the greatest use of the general practitioner with greater limitation on specialists' services calling for higher fees.

It is possible to offer such coverage, including 30 house or office calls per year for the subscriber and

*Reprinted from the New York State Journal of Medicine*

15 for each dependent to the family, for $36 a year. The same coverage can be provided for a single individual for $15 a year.

In addition to the coverage specified above, this contract does make certain specific allowances for specialists' services. For instance, for any one disability a maximum benefit of $5 is allowed for consultation with a specialist and an equal sum for a special examination. Also, during one year each subscriber and his dependents are allowed a sum of $10 for each of a number of special medical services, such as diagnostic x-ray service and physiotherapy. Such a limitation of specialist service was found necessary when, for example, under the Western New York Plan's old contract, it was found that everybody with throat trouble wanted a specialist and every woman wished her children to go to a pediatrician. This entailed considerable increase in cost and could not be afforded at the premium rate offered.

One word of caution is necessary. It is natural that from year to year certain modifications of the contract have to be made. This can be done only if every contract expires at the end of a year and is renewed at that time.

## The Nation-Wide Health Program Advocated by the Health Program Conference

It is probably fortunate that the operation of American democracy is such that a group of twenty-nine physicians, economists, representatives of organized labor, social workers and hospital administrators could sit down and together work out a nationwide health program which apparently is free from Federal politics and which does represent a certain medical opinion. It is no secret that this medical opinion is a very restricted and prejudicial one but, for that matter, so might be called the opinion of organized medicine as represented by its spokesmen in Chicago. Ever since the publication of the report of The Committee on the Costs of Medical Care, of which the late Walter R. Steiner was a member, American Medicine has had sufficient warning and time in which to develop a program of medical care of proper scope to meet the demands created by a national social evolution. The story of the past twelve years needs no recounting at this time.

The program formulated in the report presented to the National Conference on the Problems of Medical Care which met in Washington in December 1944 rests upon ten principles:

1. Comprehensive coverage and service;
2. Spreading of costs;
3. Distribution of facilities according to community health requirements;
4. Encouragement of group medical practice with hospitals as professional service centers;
5. Determining policy through participation of those who receive and of those who furnish service;
6. Responsibility of the professions for strictly medical activities;
7. Freedom for physicians and patients;
8. Adequate payment of physicians and hospitals by methods which encourage quality and promote economy of service;
9. A national system;
10. Local administration of services under national standards.

The specific aims of the program are:

1. Comprehensive medical services and facilities shall be physically and financially available to all the people;
2. These services shall be so organized and supplied as to be scientifically efficient, and as economical in cost as is consistent with quality;
3. The services shall be adequately and securely financed;
4. Professional opportunities shall be improved, and adequate income assured the persons and institutions furnishing service.

In its report the conference declares that plans calling only for hospitalization, surgery, or benefits for "catastrophic illness" alone, do not express the ideals of medicine nor serve most effiectively and economically. It also declares that plans providing cash benefits only are even more limited in medical and economic value. Therefore the conference proposes a national system of health insurance to which employees, employers and self employed persons would be required by law to contribute in proportion to earning capacity and under which, in addition, low income bracket families would be provided for by supplementary taxation. It has been determined that American families ordinarily spend directly about 4 per cent of their earnings for all kinds of medical services, of which about three-fourths goes for physicians and for hospital services. The proposed plan would call for little in the way

of new outlay of money but would regularize the already existing payment of the 3 per cent for physicians' services and hospital expenses. This in the minds of the conference sponsors would obviate the double system of medical care now developing, representing (1) a poor man's system supported by taxation, under welfare departments and other governmental auspices and restricted to indigent and other needy persons, and (2) an insurance system for employed persons and their families, supported by payments from them and sometimes from their employers also.

Certain features of this proposed health program are to be commended. Group practice using the hospital as the unit center is encouraged. This has long been considered by many physicians a step toward more efficient and economic medical care which has merited more positive support by organized medicine than it has received. Preventive medicine will be a major plank in the proposed program. The problem of the rural areas has received considerable attention. Research will be encouraged and adequately compensated.

The program recognizes as basic protections against regimentation the general principles of freedom for people in choice and change of medical resources, and the corresponding freedom for physicians to accept or reject patients. These protections, according to the report, should be extended beyond what exists today. Three methods of payment, or combination of the same, are recognized: salary, capitation, and fee-for-service. Because of the expense involved as well as its possibilities for abuse, the fee-for-service method of payment is discouraged, except for specialist services under certain conditions.

Administration of the program follows three basic principles:

1. National collection of funds, integrated with the collection of funds for other branches of social security.

2. Local and State administration of services under national standards and national supervision.

3. Unified administration of the medical services; or, where unification is not feasible, machinery for coordination to be established.

It will be seen then that administration is to be decentralized with responsibility resting with local administrative organizations. Administrative responsibility is to be divided functionally, on the operating level, between the professional and financial fields. The policy determining body and the administrative officers are to be aided by advisory councils composed of informed persons from professional and lay groups.

In his editorial comment on this program,* Dr. Fishbein calls attention to a closing paragraph:

"There are numerous, important regulations which cannot be specified by law. Some of these regulations may be national in application. Others will be designed for certain localities, or will relate only to particular forms of service. These regulations must be worked out by the administrative authorities and when adopted have the force of law."

As already stated, the administrative responsibility is to be divided between the professional and the financial fields and when so arranged should not constitute a carte blanche when agreed to by the medical profession or a turning over to non medical administrators for any disposition they may see fit, as is feared by the editor of our national publication.

Perhaps the stimulus afforded to the solution of the problem of medical care by such a concrete proposal as above outlined is just what organized medicine needs. We hope so. As the *New York Times* has said,† "it does much to remove some of the objectionable features of the Wagner-Murray-Dingell bill, and it avoids the pitfalls that face physicians who plead for the status quo and the fanatic reformers who would leave everything to the Government."

**Journal A.M.A.*, Nov. 4, 1944
†*New York Times*, editorial, Dec. 9, 1944

## X-ray Services in Prepaid Hospital Plans

The American Hospital Association Hospital Service Plan Commission recommended a new comprehensive contract at its Cleveland session and urged all Blue Cross Plan executives to talk their trustees into adopting the uniform contract. It includes anesthesia up $10 per admission, if regularly provided and billed by the hospital; radiology up to $15 per admission, if regularly provided and billed by the hospital; clinical and pathological laboratory service; and electrocardiograms.

No one seems to know just how this recommended unform contract can become nationwide so long as a considerable number of the Blue Cross Plans are operating under agreements with the medi-

cal society in their state forbidding the inclusion of any medical services among the service benefits provided.

Efforts to extend benefits in several areas by adding the services of radiologists, pathologists, and anesthetists to the benefits guaranteed by participating hospitals in plans which now conform to principles promulgated by the A.M.A. are being strenuously opposed.

In Massachusetts, the Council of the state medical society unanimously rejected a request from Blue Cross that radiologic service up to $15 per annum be added to hospitalization benefits.

In Colorado, the state society rejected a proposal for the addition of x-ray services to benefits offered by Colorado Hospital Service. Instead, Colorado Medical Service, operated by the Colorado Medical Society, is preparing to offer a supplemental contract paying cash benefits on a fee basis for radiology, pathology, and anesthesia. It will be sold to Blue Cross subscribers along with their contract for hospital service.

In Iowa, a compromise similar to that previously effected in Washington has been adopted. Cash benefits are paid by Blue Cross to the physician or his agent for radiology, pathology, and anesthesiology when incident to hospitalization.

The Florida Radiological Society is actively opposing a compromise agreed to by a committee of the Florida Medical Association under which Blue Cross includes "x-ray technical service" among hospital benefits. Radiologists are expected to bill subscribers for "professional service." The Society quite properly points out, according to the American College of Radiology News Letter, that such division of radiologic practice into technical and professional phases violates principles already agreed to by the American College of Radiology and the American Hospital Association. The specific principle referred to reads as follows: "The American Hospital Association and the American College of Radiology view with disapproval the proposal that actual cost of films and associated overhead be separated from the professional charges of the radiologist or that the responsibility for this department be divorced from the hospital. While in many instances this would be a financial relief to the hospitals, it would probably result in frequent omission of the radiological consultation with a specialist in radiology, would mean less efficient radiological service with potential legal complications and would tend to create difficulties with national and other organizations requiring supervision of the radiological work by a competent radiologist."

## Medical Care Insurance Installed by Hoffmann-La Roche

What may be the most complete plan for medical care insurance conceived to date by private industry will go into effect January 1, 1945 among the 1,600 employees of Hoffman-La Roche, Inc., of Nutley, N. J. The firm is one of the nation's leading manufacturers of pharmaceutical specialties and one of the largest producers of vitamins.

In addition to reimbursing employees against costs of physicians' consultations and treatments at home, hospital or in the doctor's office, the plan provides coverage against hospital, surgical and obstetrical expenses of both employees and their dependents, with full cost borne by the company. Every full time employee on the payroll as of January 1 is covered. All classes of employees, regardless of position or salary, receive the same liberal benefits.

The Roche Plan for Hospital and Medical Care is the outcome of prolonged study by employees and management insurance committees and supplements a company plan for life insurance, retirement annuities and sick benefits which has been in existence for some years. The new plan is underwritten by the John Hancock Mutual Life Insurance Company of Boston.

Reimbursement for doctor bills connected with sickness or injuries not coming within the scope of workmen compensation laws begins with the very first visit with the doctor, provided the employee is unable to perform the duties of his or her occupation and is absent from work. This reimbursement is to the extent of $3 per visit in the employee's home or at a hospital, and $2 for consultation or treatment in a physician's office. This is paid up to a maximum of $75 for treatment during any one continuous period of disability. Employees 60 years of age or over are limited to a $75 maximum benefit during any calendar year since the normal retirement age for Hoffman-La Roche employees is 60 in the case of women and 65 for men. After an employee returns to work following an absence of 7 days or more, reimbursement is also provided for up to three calls for physician's treatment which may

be necessary as a result of that specific disability during the next 31 days. Prenatal and postnatal care of female employees who become pregnant while insured are reimbursed for up to six medical visits.

Against expenses for hospitalization and surgical fees the Roche plan for hospital and medical care provides a daily hospital benefit of $6 a day for both employees and their dependents, plus an additional $60 maximum for other charges made by the hospital. The daily benefit is paid up to a maximum of 31 days for any one disability, with no limit on the number of disabilities or on the total days of hospitalization in any one year. In maternity cases the $6 daily benefit is paid up to a maximum of 10 days on employees' wives and in the case of female employees who have babies this is extended to 14 days. The reimbursement for surgical operations is up to a maximum of $150 for both employees and their dependents.

## Nebraska Incorporates Cash Indemnity Plan

The Nebraska Service Plan has been incorporated and is now operating as a cash indemnity non profit prepayment sickness insurance plan. It represents the plan originally sponsored by the Omaha-Douglas County Medical Society of Nebraska and offers surgical, obstetrical, pathological, x-ray and anesthesia benefits to subscribers. The business management of the Nebraska Surgical Plan will be administered and the contracts will be sold and serviced by Associated Hospital Service of Nebraska.

## Rhode Island Sickness Fund

Authorities state that the Rhode Island state operated cash sickness insurance system paid out $724,519 more than it took in during the six months from April 1 to September 30, 1944. Receipts by the fund have been declining and the amount of the average benefit check increasing.

## New Assignments, Office of the Surgeon General

Major L. E. Morrisett, MC, of Greenwich, Conn., formerly Chief of the Ear, Nose and Throat Section, Borden General Hospital, Chickasha, Okla., assigned Chief of the Otolaryngology Branch, Surgical Consultants Division.

Major I. Smith Homans, Jr., SnC, of Hartford, Conn., formerly Field Representative, St. Louis Medical Depot, assigned to the Storage and Maintenance Division Supply Service.

## Promotions — Changes of Station

Lieutenant Commander William German, MC–USNR, of New Haven has been promoted to Commander with continuation of his station at U. S. Naval Hospital, Philadelphia.

John Chasnoff, 1st Lieutenant, MC—AUS, of West Haven has been discharged from active duty and resumed his practice.

Joseph Francis Sadusk, Jr., New Haven, has been promoted from Lieutenant Colonel to Colonel.

Robert Page Rogers, Greenwich, has been promoted from Major to Lieutenant Colonel.

William F. Stankard, Springdale, has been promoted to Captain, station unchanged.

William D. Troy, Stamford, has been promoted to Captain, station unchanged.

William B. Swarts, formerly of Greenwich and Stamford, has been promoted to Major and is stationed at Regional Hospital, Camp Robinson, Arkansas, as chief of dermatology, after having been overseas for more than a year.

Irving Friedman, New Haven, has been promoted to Major and transferred from Fort Williams, Maine, to Waltham Regional Hospital, Waltham, Mass.

William J. Bodie, Branford, has been promoted from Captain to Major and is still stationed in Boston, Mass.




MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE WAR

## REPORT
## SUB-COMMITTEE ON INTERN CURRICULUM
## STATE POST WAR PLANNING BOARD
## November, 1944

THE COMMITTEE

Thomas P. Murdock, M.D., *Chairman*
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Creighton Barker, M.D.
Secretary

The Committee on Medical Care and Health of the State Post War Planning Board designated a Subcommittee on Intern Curriculum to study intern service and intern training in Connecticut hospitals. The studies initiated by the Committee were for the purpose of determining how intern service in many Connecticut hospitals could be improved and made more attractive, to the end that the recruitment of house staffs for Connecticut hospitals might be more adequate in the future, and thereby increase the usefulness of the hospitals and attract well trained physicians to the State for intern training, with the possibility that they might permanently locate in practice here to make up natural losses.

### What Is An Internship?

In the opinion of the Committee, the internship in medicine marks the introduction of the medical student, now graduated, to the practice of medicine. It signalizes the practical application of knowledge gained by the physician in his medical school training, and is not, therefore, postgraduate medical education in the strict sense. It is, however, definitely a training period, and one in which every opportunity should be made available for the new physician to learn by precept and example from his older professional colleagues. Furthermore, inasmuch as the intern experience is the first real contact of the new graduate to the public as a physician, the opportunity for the indoctrination of the principles of medical ethics represents an important part of the experience to be gained during intern service. It becomes the duty of each hospital, and of hospital staff physicians to assume the responsibility for intern training—to be aware not only of these responsibilities, but to sort out and develop all of those opportunities which will best serve the purpose of their intentions.

### Staff Appointments

The quality of intern training within a hospital depends essentially upon two factors: first, the training, experience, and teaching ability of staff members; and second, the utilization of clinical material and other facilities afforded by the hospital. Choice of staff members is an important consideration, and the Committee recommends that physicians to be appointed as full attending staff members shall be diplomates of the respective American specialist examining boards, or if these are not available within the community, such appointments should be Fellows of one of the American Colleges.

In addition to the usual visiting attending clinicians, the Committee recommends the employment of certain full or part time medical personnel. The designation "full time" means physicians employed by the hospital on salary or other basis who give their entire time to the service of the hospital. Or, in the case of radiologists and anesthetists, "full

time" may refer to part time service in the hopsital by one or more physicians in these fields so that the hospital is covered at all times.

FOR HOSPITALS OF 100-200 BEDS

*A full time pathologist.* In addition to directing the pathological and clinical laboratory of the hospital, the pathologist would be expected to conduct formal clinical-pathological conferences each week with interns presenting cases for discussion by the attending staff.

*A full time radiologist.* The radiologist would be expected to attend the weekly clinical-pathological conferences, and to demonstrate and interpret x-ray films at the regularly scheduled formal teaching ward rounds.

*A full time physician anesthetist.* The physician anesthetist would direct the department of anesthesia, and be available to direct parenteral therapy and resuscitation, and give instruction in these fields. The full time physician anesthetist should be assisted by and should direct an adequate number of nurse anesthetists.

*A psychiatrist.* The full time services of a psychiatrist should be available in the hospital for consultation at stated periods. This service may be provided by an attending psychiatrist who is available in the hospital on full time for regularly scheduled periods.

FOR HOSPITALS OF 200-500 BEDS

*A full time pathologist.* In addition to directing the pathological and clinical laboratory of the hospital, the pathologist would be expected to conduct formal clinical-pathological conferences each week with interns presenting cases for discussion by the attending staff. The pathologist should be assisted by assistant physician pathologists and advanced technicians, based upon the quantity of work.

*A full time radiologist.* The radiologist should be responsible for the direction and operation of the department of radiology, including therapy and radium. He should be assisted by additional full time physician radiologists and advanced technicians, based upon the quantity of work. He would be expected to instruct members of the house staff in x-ray diagnosis and therapy.

*A full time physician anesthetist.* The physician anesthetist would direct the department of anesthesia, and be available to direct parenteral therapy and resuscitation, and give instruction in these fields. The full time physician anesthetist should be assisted by additional full or part time physician anesthetists and an adequate full time staff of nurse anesthetists.

*A psychiatrist.* A psychiatrist who would devote at least one half of full time to regular service in the hospital for examinations and consultation. This service might be supplied by an attending psychiatrist retained for this purpose.

TEACHING COORDINATORS

The Committee recognizes the desirability of a full time physician in the capacity of a teaching coordinator for the intern staff, particularly in larger hospitals, and recommends that wherever possible such an official be employed. The Committee also suggests the employment of such a full time teaching coordinator by voluntary groups of small hospitals, who would supervise the intern training programs in these hospitals. The Committee is brought to make this somewhat unique recommendation in the light of experience that has been had by one of Connecticut's most successful hospitals in the field of intern training.

REGISTERED PHARMACISTS

The full time services of registered pharmacists are deemed essential in all but the smallest hospitals. The pharmacist should be useful in the teaching program to give instruction in the economics of treatment, and the relative costs and availability of therapeutic agents.

REMUNERATION FOR FULL TIME STAFF

The Committee recommends that the arrangements for the remuneration of full time staffs be at all times in accordance with standards established by the Joint Committee of the American Medical Association, the American Hospital Association, and the several specialized examining boards.

STAFF MEETINGS

The Committee emphasizes the primary requirement of monthly meetings of the attending staffs of hospitals, and attendance at these meetings should be compulsory for interns and members of the house staffs.

## Committee on Intern Training

The Committee recommends that each hospital appoints from its attending staff a committee of 3 to 5 members, to be known as the "Intern Committee." The administrator of the hospital shall either be a member of this Committee, or shall participate closely in the Committee's activities.

The functions and purposes of the Committee on Intern Training shall be:

1. A recruitment of house staff members, passing upon their qualifications.

2. The education and training of house staff members.

3. The assignment to services and the integration in the hospital operation of house staff members.

4. The responsibility for the discipline of house staff members.

In those hospitals where it is not practicable or desirable to employ a teaching coordinator, a member of the full time professional staff or the attending staff should serve as a coordinator for the intern training program and as the executive officer of the Committee on Intern Training.

## The Interneship

The Committee accepts as basic the Minimum Standards of Training of Interns as prepared and published by the Council on Medical Education and Hospitals of the American Medical Association, and beyond those standards makes certain recommendations.

### TYPE AND LENGTH OF INTERNESHIP

With a knowledge of the clinical facilities available, the Committee recommends that most Connecticut hospitals provide the type of internship that is traditionally known as a "rotating interneship," and only in a few instances advocates interneships in special fields, such as surgery, medicine, and obstetrics.

Because circumstances vary in different hospitals, the Committee makes no specific recommendation as to the length of service, whether it be 12, 18 or 24 months.

### REMUNERATION OF INTERNS

As a general principle, the Committee is of the opinion that the first period of internship following graduation should not be remunerative in the sense that the intern receives a salary for his services, but, in addition to full maintenance and uniforms, a modest honorarium for spending money is desirable in some instances, and that the internship should be sought by young physicians because of the intrinsic value of the teaching provided rather than for financial recompense.

## The Training Curriculum

The Committee recommends that the training curriculum include:

(a) Daily ward rounds by attending physicians on service.

(b) Weekly clinical-pathological conferences, and presentation of cases.

(c) Weekly medical and surgical "Grand Rounds" by the chief of services.

(d) Monthly meetings of the attending staff, and compulsory attendance by the house staff.

(e) Attendance upon a tumor clinic.

(f) Assigned reading and the abstracting and presentation of material from the medical literature. Organization of a "Journal Club."

### SPECIAL TEACHING

The Committee recommends the utilization for teaching purposes of medical personnel in special fields that may not be members of the attending staff of the hospital. Particular reference is made to the use of members of staff of public hospitals for the care of the tuberculous and for the mentally sick, and of public health officials.

In those hospitals that do not have facilities for the care of contagious diseases, arrangements should be made for visits to contagious diseases hospitals by members of the intern staff, or instruction by physicians especially qualified in the control and care of contagious diseases.

### THE LIBRARY

Each hospital must be provided with a working library, and members of the intern staff encouraged to use it. Adequate appropriation should be sought from the hospital to purchase modern texts in the field of medical science, and a useful group of periodic medical literature, including journals in the common special fields of medicine. It is suggested that some of these journals may be acquired by gift from members of the staff who subscribe to them, and are willing to deliver them gratuitously to the hospital later.

## Suggested Programs

The Committee submits two samples of teaching programs that are in operation in Connecticut hospitals. The first is from a hospital of 150 beds, the second from one of the State's largest hospitals.

### Program I

Participation in

1. Clinical-pathological conferences (weekly).
   a. Tumor conference, one each month.
   b. Lecture by visiting speaker, one each month.
   c. Case presentation, two or three each month.

2. Surgical staff conference (weekly).
   a. Review of literature on a specific subject by staff men or intern.
   b. Original papers on clinical observation by staff member or intern.
3. Staff meeting (monthly).
   a. Review of selected death cases.
4. Intern seminar (once or twice weekly).

*Introduction to surgery.* Histories and physicals, shock, surgical dressings, surgical technique, operating assistance, intravenous therapy, rectal tube, Miller-Abbot tube, gastric decompression. Emergency service—accident room.

*Introduction to medicine.* Histories and physicals, transfusion, use of blood plasma, spinal puncture, venipuncture.

*Introduction to laboratory.* Laboratory techniques, blood cytology, urinalysis.

*Introduction to obstetrics.* Histories and physicals, pelvimetry, classification of pelves, delivery room technique.

*Introduction to pediatrics.* Histories and physicals, infant feeding, infant medication.

*Medical records and medico-legal problems.* The intern and the patient's family, the liabilities of the intern under the law, hospital records as legal documents, the release of information, court testimony.

### Program II

Daily rounds by the attending and/or asssitants, residents and interns on the service.

Grand rounds (weekly) on all services by attending, assistant, residents, and interns on service, a member of the pathological staff, a member of the radiological staff, the deititian if requested, the physiologist if requested, and consultants by request. Attendings to be present for at least one-third of the Grand Rounds meetings.

*Clinical-pathological conferences.* Bi-weekly. For all attendings and house staff. One hour.

*Pathology conferences.* Weekly. For pathologist and house staff, and invited guest from the staff or outside. One hour.

*Seminars.* Weekly. Varied programs as introduction to practice. Discussing everyday office problems and practical medicine, and a gradually progressive program beginning with the examination of the patient, recording of findings, treatment and specialist consultations. One and one half hours.

*Staff meetings.* Monthly business meeting. One half hour. Discussion of selected deaths, or presentation of scientific papers. Not to exceed one and one half hours. Presentation of case by intern on service at time of death. Discussion by staff, with attending physician as moderator. Discussion of autopsy findings by pathologist, and presentation of other data by consultants. Summation of case.

*Tumor conferences.* Monthly. Attending and house staff.

*Clinical Conferences.* For house staff and members of individual services. To follow Grand Rounds, but not to be restricted to cases presented at rounds. Weekly.

*Staff luncheons.* Bi-weekly. One hour. Luncheon, followed by scientific program of one half hour. Program to be varied, and to include such subjects as war medicine, late advances in medical fields, and demonstrations of new techniques, speakers, and motion pictures.

*Special conferences.* At varied intervals. Special tumor conferences. Chemical or physiological conferences, medical licensure and medical-social topics, by guest speaker, for house staff and others interested.

#### Report on Program

Forms, for attending and resident staff, submitted monthly by attending physicians, residents and interns, with pointed questions about the program, and those in it, and recommendations for improvement or change or extension of the program. Reports to be received by the teaching coordinator or the Intern Committee, and to remain confidential.

### Suggested Subjects For Presentation

Intern committees, and others responsible for the arrangement of conferences, seminars, and addresses, will be familiar, of course, with suitable subjects for discussion, but the Committee has set down certain important topics to serve as a guide for the arrangement of teaching sessions.

*Medicine*—hypertension, coronary diseases, circulatory accidents, disturbances of the peripheral circulation, chemotherapy.

*Surgery*—lesions of the abdomen, including perforations, visceral ruptures, abdominal hemorrhage, surgical treatment of pulmonary disease.

*Pediatrics*—feeding problems, juvenile endocrinology, juvenile diabetes, abdominal pain in children.

*Gynecology*—benign lesions, uterine tumors, menstrual disorders, pelvic infections, malignancy of the uterus and cervix, obstetrics, management of

obstetric emergencies, operative obstetrics, toxemias of pregnancy, pneumonia and acute infections during pregnancy.

*Otolaryngology and ophthalmology*—acute otitis media and mastoiditis, foreign bodies in the respiratory and upper digestive tracts, cataract and glaucoma infections of the eye.

*Orthopedics*—fractures of the extremities, fractures of the vertebra, with and without cord damage, congenital deformities.

*Dermatology*—acute inflammatory diseases of the skin, benign and malignant growths of the skin, blemishes and chronic eruptions, occupational dermatosis, metabolic disease, endocrine, dyscrasis, thyroid disease.

*Urology*—specific infections, pathology of the kidney and ureter, congenital abnormality.

*Diseases of the central nervous system*—central nervous system syphilis, psychoses, psychoneuroses, epilepsy, laboratory and equipment and techniques, essential laboratory equipment, common clinical microscopy, new procedures in quantitative blood chemistry, autopsies.

*Legal medicine*—medical licensure, the expert witness, the coroner and medical examiner, workmen's compensation laws.

### Residencies

The Committee is of the opinion that there are hospitals in the State which have sufficient clinical material and teaching facilities to warrant their considering the establishment of residencies in some of the special branches of medicine. The instruction of residents and the maintenance of a "residency system" in a hospital is more complicated and entails even more time in instruction on the part of staff members than does a creditable intern training program. However, residencies in clinical subjects are in increasing demand by young physicians who have completed their internships and the presence of opportunities to continue in the residencies in the same hospitals where the interne has served is an attractive advantage to the intern seeking appointment. Furthermore, it is the opinion of the Committee that if more residencies of approved grade were available in hospitals here, an additional number of well trained young physicians would settle in communities within the State where the need for the services of many is already apparent.

This report and its recommendations have been prepared to serve as a guide to the hospitals of Connecticut in improving the quality of internships available here. It is realized that all of the proposals made herein cannot, and perhaps should not, be accepted by all hospitals because local circumstances make for varying conditions of application. It is, however, submitted as an ideal and useful pattern to the hospitals of the State, and it is recommended that it be published for wide distribution among the hospitals and the physicians interested in intern training.

## PLANNING FOR NURSING IN POST WAR PERIOD

Marion H. Douglas, *Hartford*

The Author. *Chairman, Connecticut Nursing Council for War Services*

The tremendous demands which are being made upon the nursing profession today and the uncertainty as to the method by which the many and varying needs are to be met are the primary concern of the Nursing Group. Detailed planning for the post war period is hardly practical at this time, but the profession as a whole is cognizant of the need for studying our assets and liabilities, evaluating our methods, and modifying our war time machinery in a way that will conserve the desirable factors which have demonstrated their value in a period of great strain and readjustment.

The leaders who have been responsible for the working out and administration of the plans for realignments of service to meet the changing needs have had a difficult and challenging job. The organization and the development of the program in Connecticut has passed through many stages. Beginning as the State Nursing Committee on Defense sponsored by the Connecticut State Nurses Association and subsequently recognized by the State Defense Council as the Subcommittee on Nursing, it later

redefined its objectives and its plan to conform to the National Nursing Council for Defense, now known as the National Nursing Council for War Service. The general line of organization has been from National to State to Local Nursing Council with the emphasis being placed, at all times, upon the responsibility of the local group for carrying out the program in accordance with national objectives, trends and programs.

The purpose of the Nursing Council for War Service is to make nursing service available as needed to the Armed Forces and to civilians and keeping those services at the highest possible level in war time. Until very recently the major activities of the Council have been associated with the Procurement and Assignment of nurses for the Armed Forces and the recruitment of young women for the schools of nursing. The Committee on Procurement and Assignment has been responsible for classifying all the nurses and referring to the Red Cross Recruitment Committee all those eligible for military service (class I). While this is still our foremost consideration, the question whether other provision will be made which will supplant the activities of this committee is one which has a bearing on all the other activities of the Council.

The task of the Recruitment Committee for schools of nursing has been a colossal one and has resulted in securing almost twice the number of students that have previously been admitted each year to our schools of nursing. This is a continuing program and one which requires constant vigilance and stimulation.

As these wartime needs diminish—and diminish they will as the end of the war draws nearer—the conversion of our war nursing program to peacetime needs will supplant our other activities. Meanwhile the superstructure for launching the program must be built, and built in such a way that we may keep and develop those gains which have been achieved by the war sacrifices.

The first step in this direction has been the creation of a National Nurses Planning Committee of the Nursing Council. The objectives of this Committee have been outlined as follows:

1. Determine the needs of the nation for nursing care.

2. Determine the number of nurses required to meet immediate needs for all types of nursing care.

3. Provide for meeting additional needs as social programs advance.

4. Educate nurses to give the best service made possible by current scientific knowledge.

5. Promote, develop and adopt personnel policies and practices which will be satisfactory to employer and employee, and remuneration commensurate with the services rendered to society.

6. Promote and support plans which will assure nursing care for all in need of it, through an equitable distribution of the service cost.

7. Promote, develop and establish standards to guard the public and the nurse.

8. Convince the public that the service offered by nursing contributes toward healing the sick and promoting positive health, and warrants the use and support of a comprehensive community program.

9. Maintain a progressive program of information directed to nurses to help them understand and accept their responsibilities and opportunities.

10. Support the above program without regard to race, creed, color, economic status or geographical location.

At a recent meeting of the National Planning Committee it was voted to inform the individual nursing councils that they should continue to function as a coordinated group after the war emergency is past.

Miss Effie J. Taylor has been appointed chairman of the Planning Committee of the Connecticut Nursing Council for War Service. Although this committee has not yet been called together, the general thinking seems to indicate that they are approaching the problem with an appreciation of the need for using every facility and resource suggested by the National Nurses Planning Committee and the Post War Planning Board and of adopting them or formulating more appropriate plans to meet the particular needs of the people within our State.

While the profession of nursing is the agency and avenue through which plans concerned with nurses and nursing are developed and put into action, it is agreed that these should be worked out in collaboration with the medical profession, the hospital association, and the other groups working in this field to organize and implement measures concerned with health and welfare in which the nurse must play a roll.

Some of the outstanding problems which the Committee has listed for consideration are:

1. Finding desirable places for the returning nurses.

2. Remedying the shortage of nurses in hospitals.

3. Assisting in the broad projected expansion of hospitals.

4. Developing the educational nursing resources in the State.

5. Planning for the use of aides and other auxiliary workers who have given such fine service during this critical period.

6. The education of the negro nurse.

7. Counseling and placement of nurses.

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## Strength of the Army Medical Department

In connection with the recent announcement that the Army is no longer recruiting physicians, the following figures are of interest:

The Army Medical Department has grown from 8,010 at the beginning of World War I until it now numbers 680,891. Of this number approximately 44,651 are in the Medical Corps, 14,948 in the Dental Corps, 2,012 in the Veterinary Corps, 2,364 in the Sanitary Corps, 15,078 in the Medical Administrative Corps, 59 in the Pharmacy Corps, 40,305 in the Army Nurse Corps, and there are 559,327 enlisted men, 813 Physical Therapy Aides, and 1,334 Hospital Dietitians.

## Audio-Visual Aids for Reconditioning Program

Emphasizing the importance of audio-visual aids in the reconditioning program, all Army general hospitals in this country will be equipped with audio-visual libraries. These libraries, which will include movies, recordings and exhibits, will be used in connection with courses given convalescent soldiers and in addition will provide the men with recreational and diversional facilities. A course in the use of audio-visual aids is being included in the curriculums for the Reconditioning Department at the School for Personnel Services at Lexington, Va.

## Whole Blood Flown Direct to Paris

Blood from American civilians is now flowing through the veins of soldiers wounded in Europe within 24 hours after it is donated in this country! On October 12 the Army Transport Command began flying whole blood direct to Paris instead of first to a relay station in Scotland. As a result the blood is available for transfusion within 24 hours after it is drawn from "O" type donors in Boston, New York and Washington. More than 750 pints is now being flown across daily—but the need for both whole blood and plasma is becoming more and more urgent as the number of casualties increases.

## Reduction in the Medical Corps of the Army

A moderate reduction in numbers of Army Medical Corps officers is necessary in order to remain within presently allotted ceilings, the Office of The Surgeon General has announced. The need for Medical Corps Officers in senior grades who are assigned principally to administrative duties is less acute than formerly.

A Board of officers recently appointed in the Office of The Surgeon General is carefully considering the physical and other qualifications of all Medical Corps officers of the various components of the Army and their essentiality to the war effort.

As a result of this Board's study, it is anticipated that a number of separations of the above group will occur in the moderately near future. Regular Medical Corps officers will be accorded retirement privileges under the provisions of Section II, Ar. 605-245, June 17, 1941, and Reserve, National Guard, and AUS Medical Corps officers will be given the opportunity of returning to the practice of medicine in a civilian status by relief from active duty or discharge.

## Head Wound Gas Mask Now In Production

A gas mask to protect head wound patients from war gas has been developed by the Chemical Warfare Service at the request of the Medical Department, and is now in production, the War Department has announced.

The mask is the first such device especially designed to protect patients with bandaged heads, faces, or jaws. It consists of a silk like plastic hood to which an air purifying canister and an outlet valve are attached. A flexible window across the eyes provides clear vision. Air is drawn into the mask by the ordinary breathing of the wearer.

The mask is pulled over the head like a sack, and experiments at the Medical Research Laboratories have shown it to be comfortable to the wearer as well as efficient.

## Whole Blood Quota Raised

In his talk on the Army Hour broadcast over the National Broadcasting Company Network, Major General Paul R. Hawley, Chief Surgeon of the European Theater of Operations, said that the pre-invasion estimate of blood transfusions of one pint for every five wounded men was too low. "Battle experience," he said, "has shown that we must have one pint for every two casualties."

Five special centers have been set up on the East Coast and three on the West Coast where "O" type blood is collected and flown daily to the theaters of operations.

## Critical Need For Army Nurses Continues

Out of 27,000 recruiting letters sent by the Army Nurse Corps to nurses classified as 1-A for military service by the War Manpower Commission, only 710 replies have been received, and less than a third of these are from nurses qualified for commissions.

While the drive to recruit Army nurses lags, the number of patients being evacuated from overseas to the United States has been increased almost 300 per cent. In addition the overseas requirements for nurses continues to grow, with the quota for the month of December alone set at approximately 1,000 nurses.

## War Medicine: Vol. 6, No. 5, November 1944

There are two articles in this issue emanating from our Allies. The first entitled, "Problems and Treatment of Immersion Blast in the British Navy" is written by Surgeon-Commander E. P. P. Williams, O.B.E., and discusses the occasions which lead to immersion blast injuries, emphasizing certain simple facts which are known and which help to protect the seaman, namely, the inflated life jacket and the horizontal position preferably on the back, which should be assumed in the water, utilizing any floating wreckage to lift the body higher out of the water if possible. The author calls attention to the principles of first aid treatments for immersion blast injury which are rest and warmth, and the avoidance of stimulants and sedatives. The second article from our Allies is on "Peptic Ulcer in the Canadian Army (1940 to 1944)," by Major W. R. Feasby of the Royal Canadian Army Medical Corps. This report deals with the cases of men of the Canadian army whose complaints indicated one of the dyspeptic syndromes. It follows cases originating in England or Canada from 1940 to 1944 and is a continuation of a similar study begun at the outbreak of the war. The striking conclusions are that, although peptic ulcer is usually a serious enough disability to warrant discharge from the army, yet the soldiers who have had a perforation present an exception to this rule. However, with the Canadian army in England, the author calls attention to the fact that only 10 per cent of the men returned to duty with a healed peptic ulcer were able to carry on for a reasonable length of time, whereas in Canada a higher selected group of men with healed duodenal ulcer were able to carry on indefinitely, provided the latter enjoyed special feeding arrangements and, in many cases, a home environment. Peptic ulcer causes serious wastage of man hours, and, in the words of the author, sufficient research to warrant the best study possible.

The problem of head lice, crab lice, body lice and scabies is covered in two articles eminating from the Bureau of Entomology and Plant Quarantine at its station in Orlando, Florida. SYLN is the preparation which has been found most efficacious in getting rid of the various lice.

"Residuals of War Wounds of the Extremities" by Captain Francis D. Threadgill, MC—AUS, calls attention to the delayed sequelae which are being experienced in this group of casualties. Four physicians at Temple University School of Medicine describe a rotating-tilting machine that produces symptoms of motion sickness. A relative simple apparatus that can be operated by a single examiner in a small room without assistance. There is a description of the criteria for rejection of applicants for the Women's Reserve, U. S. Marine Corps, who show evidence of neurological and psychiatric disturbances. The results of a study of 200 cases of scrub typhus encountered in one military command are submitted by four officers of the Medical Corps, AUS. There are twenty-four pages of abstracts from current literature including French and German, in addition to English and American. Six book reviews complete the issue.

### NEW CONVALESCENT HOSPITAL ESTABLISHED

The War Department has announced the establishment of a new convalescent hospital at Camp Upton, N. Y. The hospital will be under the command of Colonel Edward A. Coates, MC.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## A Summary of Combat Medicine and Surgery from Paul P. Duzmati, 1st Lieut., AUS, Bridgeport

Holland,
9 September, 1944

Life and practice in the combat zone is so different from civilian routine. Here, while the weather is cold and rainy, until your station is in a sea of juicy chocolate mud, and amidst the shaking blasts of artillery, aerial bombing, and creeping blackout; the most aseptic practical painless surgery and modern medicine are both unselfishly offered to all alike. Every human effort and all the up to date forms of surgery and the healing arts are given to every soldier regardless of race, creed, or rank; so that he may be evacuated to the United Kingdom (U.K.); then to the U. S. A. for final exit home as humanly cured as man knows how.

The modern aids in medicine and surgery are the introduction of sodium pentothal for intravenous anesthesia and inductive narcotherapy; penicillin, for treating and preventing the gram positive cocci infection, syphilis, gonorrhea, meningitis and gas gangrene; the sulfa drugs to act as cocci infection preventives and cures; and plasma, with or without storage blood, is utilized as the staff of life in shock, hemorrhage and pre or post operative conditions. However, we cannot forget the great importance of quinine, second, that of atabrine. For one is most surprised to know the great number of primary and recurrent malaria cases. Soldiers who may have been infested by the plasmodia in Africa, Italy, Sicily, and our States, never showed signs of fever, chills, emaciation until they faced the severity of European climate, combat exhaustion, food deficiency and mental anxiety, all these lowered the "X" factor of body resistance, such that these soldiers were now unfit for combat. One gets to believe that infection plus physical lowered resistance are two factors in malaria symptomology. Then, again, one begins to doubt if malaria is ever really cured. Here, I thank the American druggist for offering to their comrades in arms the precious quinine that they could have sold to the public for higher prices and less vital therapeutic uses. For quinine is far superior to atabrine in preventing and conquering malaria symptoms.

Thanks to our civilian drug firms; they made the supply of penicillin plentiful for the combat casualties. Penicillin is routinely given in all casualties of the buttocks, abdomen, chest, compound fractures and brain. It is also used for active sulfa resistant gonorrhea, syphilis, gas gangrene, osteomyelitis and pneumonia. Dosages range from 20,000 U to 40,000 U q. 4 hours for 24 to 72 hours, depending on the severity of the disease. It's a marvelous miraculous drug, and thanks to Dr. Fleming for popularizing it. Many a soldier has gone home healed, where if it were not obtainable, he would be dead.

Routinely every casualty is given one c.c. of tetanus toxoid at the battalion aid station or farther in evacuation. Thus far no cases of active tetanus were observed in many thousands of wounded.

Pentothal sodium, in a 2½% solution, has been a miracle anesthetic for its ease of use, fast action, and safety. Our cautions for its use are: proper preanesethetic medication, usually morphine gr. ¼ or ⅛ with atropine gr. 1/150 or 1/100 (H), a half hour before or ten minutes before via vein; incidently atropine alone may be used but it's less preferred; slow induction; cleared unobstructed air passage; freshly prepared daily solutions; early and proper insertion of the air way; and thus oxygen is unnecessary if pentothal is given only in the quantity required as prescribed by the surgical need. Over dosage of pentothal is not necessary, and dangerous. Pentothal sodium in a 2½% solution has a major therapeutic value in the inductive stage to narcotherapy in neuropsychiatric cases, namely, "shell shock or combat exhaustion." Especially in cases of amnesia, paralysis, hemiplegia, blindness, deafness, and anxiety neurosis. These cases are pitiful; perhaps physically sound but mentally a complete wreck. Thus pentothal induction with added pressure stimulation over the eye ball, and suggestion, all these together tend to stimulate the brain's circulation, so that those particular areas of the brain are stimulated; thus permitting a new flow of blood in the damaged brain so the patient begins to react slowly or even violently until that phase is released or unlocked. Thus that psychotic phenomena is

overcome, namely, as the amnesic begins to recall the time, place, and circumstances when a German "88" shell exploded nearby, thus killing his platoon, or the deaf begins to hear, and the blind to see.

Due to the generous cooperation of the American public, physicians, and Red Cross, every wounded boy has plenty of life-giving plasma and stored blood. These are kept in thermo cans and in refrigerators at all hospitals. Plasma may even be given at the battalion aid station. Plasma and blood with intravenous saline and 5 or 10% glucose has been extensively used in combating shock, hemorrhage, and operative risks. We have noted that after repeated transfusions of blood, patients will show severe transfusion reactions; especially when a transfusion is repeated after an elapse of one week or more; even though cross matching was compatible. Thus one comes to the importance of recognizing the Rh factors of blood. Also there was noted that repeated blood transfusions to nervous, anxious, undernourished fearful patients will cause minute clots which lodge in the mucosa of the stomach, thus causing acute, serpiginous, multiple, bleeding ulcers of the stomach; these often are fatal. Whereupon if a transfusion is given to these cases of bleeding ulcers, a severe reaction and shock ensues.

Sodium amytal is the sedative preferred by the Army. It is called the "blue 88" because the capsule is of blue gelatine, and since it is used chiefly as the best barbital derivative in narcotherapy upon combat exhaustive casualties. The average dosage is from 20 to 60 grains in 48 hours. Patients are awakened for three meals and for toilet visits. After this narcotherapy patients are given two days to get rid of the drug effects: then they are either rehabilitated or experience another adventure with the "blue 88." This sedative has found great use in combination with morphine in cases of severe burns. Sodium amytal replaces morphine in those that possess a morphine allergy. Used with 1% procaine hydrochloride, long and extensive surgery is performed. By block or local infiltration, 1% procaine has been extensively utilized on surgery of the scalp, neck, and extremities. Pentothal sodium has been contraindicated in surgery upon the chest and lungs, neck and abdomen where closed ether and oxygen under pressure via an intratracheal tube proved more satisfactory. However, we noted that sodium pentothal is a fine inductive anesthetic before switching to oxygen and ether.

Definitive treatment of all wounds occurred in combat is outlined thus. The wound area is cleaned with soap and water; an antiseptic is applied about the wound, not on to the wound; then complete debridement or excision of all traumatized devitalized tissue ensues; next sulfanilamide powder is dusted in the wound; then sterile vaseline gauze is laid over the wound and edges, not packed into the wound; then a sterile firm bandage completes the treatment. All extensive traumatic combat wounds are treated as mentioned, then a cast is applied. No battle wounds are sutured or packed, all must be left wide open. I have noted that some German medics would enlarge a wound, then pack it tightly with iodoform or vaseline gauze, thus resulting in extensive sloughing and toxemia because no drainage existed. In perforating wounds after debridement is done, the prevailing path of the missile is never packed nor is there a vaseline drain placed through and through, for no drains are placed into the cavity, only sulfanilamide powder is dusted into the hole and then it is covered by sterile loose vaseline gauze. Thus plenty opportunity is offered for drainage and healing. Following surgery, every patient was given sulfadiazine, gm. 1.0 q.i.d. for three or four days. Penicillin was routinely given for skull fractures, compound fractures of long bones, fractures of the hip and spine, wounds of the buttocks, abdomen, and bladder. Usual dosage was 20,000 to 40,000 Units q.i.d. for twenty-four to seventy-two hours. Simultaneously, sulfadiazine gm. 1.0 q.i.d. was given with plenty of fluids. Incidentally, if fluid intake and output were small, sulfadiazine is reduced or even omitted.

In all burn casualties, the administration of plasma and intravenous fluids is routine. The general local treatment consists in cleaning the burned area with soft soap and water; rinsing with normal saline; then the blebs are opened and all loose destroyed tissue is removed; followed by another saline irrigation. The sterile sulfadiazine cream pads are firmly laid over the burned area. Next a well padded firm bandage is applied. This dressing remains intact for seven to ten days, provided a sulfa reaction or toxemia fails to appear. Orally sulfadiazine gm. 1.0 q.i.d. with plenty of fluids is given, along with a semi-solid high vitamin diet. For pain and discomfort, morphine gr. ¼ or 1/6 (H) or codeine gr. ½ or 1.0 with sodium amytal gr. III is preferred. Thus a patient is ready for evacuation, or for early skin grafting. Eye burns are treated by instilling ophthalmic butyrin sulfate merthiolate jelly beneath the lids, then covering with a sterile eye bandage.

In all fractures, especially compound, the routine principles of debridement, foreign body removal, sulfanilamide powder instillation, vaseline gauze coverage and sterile bandage were used before a cut cast was applied. All casts were well padded, especially over the pressure points, and all casts were cut down to the stockinette or skin. All wounds were left wide open, none were packed or sutured. No windows were cut in any cast, for this causes local edema, gangrene sloughing. These casts were inspected during evacuation, but very few were changed until the patient arrived in England. Of course, all fractures were x-rayed before and after casting. All injuries due to high explosives or severe trauma were treated as fractures. For we have learned that good casts are the best means to insure safety and healing during long, rough evacuation to the U.K. or the States.

All face, neck, and scalp injuries are cleaned thoroughly; all debridement avoided; foreign bodies easily accessible are removed; then sulfanilamide is dusted into the wound; and finally the edges are approximated with sutured and covered with sterile vaseline gauze and bandage. No drains are left in the sutured lacerations. Routinely sulfadiazine is orally administered. All these sutures are removed in three or four days.

Lacerations of the eyelid are surgically cleaned and approximated with sutures. Lacerations of the cornea with herniation of the iris or uveal bodies are treated thus. The eye is washed with boric acid solution; 2% sulfate solution is instilled for surface anesthesia, then fluorescene may be added to better visualize the damage. Under sodium pentothal anesthesia, the herniated eye substance is slightly pulled externally and excised. The remainder of the herniated substance will retract into the eye ball. Then the scleral conjunctiva is separated at the limbus, so that by means of a purse string suture a partial or a complete flap covers the cornea, thus to prevent the eye content from spilling during evacuation. Next an ophthalmic butyrin sulfate merthiolate jelly is instilled into the eye, and the lids are closed or sutured together. Thus applying a sterile eye pack, giving oral sulfadiazine, and intramuscular penicillin if infection is already present; the casualty is well protected for evacuation to the U.K. or the States, where final therapy is applied.

In battle surgery, all necessary amputations are the guillotine or circular type. The circular amputation is executed at the lowest dependent healthy part of the extremity. Thus all available tissue and bone is saved for future plastic surgery and for applying artificial extremities. Circular incision throughout the amputation is routine. Vessels are tied; nerves are not injected with alcohol; the periosteum may be infiltrated with 1% procaine to prevent further shock occurring while the bone is sawed. The tourniquet having released, hemorrhage is checked, the stump is dusted with sulfanilamide powder and covered with sterile vaseline gauze and sterile dressing. A stockinette is placed over the stump and fastened to the proximal skin by A.D. adhesive, thus the stump is transported in extension. Sodium pentothal is the choice anesthesia, routine sulfadiazine and morphine with sodium amytal are used to control infection and to give relief from pain.

We all thank the manufacturers of x-ray machines and accessories for the splendid job they performed. For the x-rays and equipment are the world's best and most plentiful. All injuries are x-rayed for foreign bodies, fracture, hemorrhage and chest and abdominal pathology prior to surgery. The service given by the x-ray personnel is perfect for they have worked long hours, giving splendid untiring results.

Meningitis, once the scourge of the Army, is well controlled and treated. Carriers are isolated and treated with sulfadiazine. Actual treatment consists of intravenous sodium sulfadiazine gms. V, first dose in 100 c.c. of distilled water or repeated q. 6 hours until oral sulfadiazine gm. ii q 4 hours is given. Sodium bicarbonate gr. X is given with the oral dosage. Blood level amounts of sulfadiazine are changed as the patient recovers. Penicillin is also used as a last resort for meningitis therapy.

All abdominal wounds, penetrating or perforating due to high explosive shell fragments or bullets, warrant an exploratory laparotomy. Lacerations of the intestines are closed by purse string sutures of silk or chromic. If the bowel is extensively lacerated and torn, repair usually calls for anastomoses, end to end, or side to side. Injuries to the colon warrant a right or left lower quadrant colostomy. After extra peritonealizing the loop of bowel for three days, the loop is incised, thus permitting feces to leave the bowel through this artificial anus, after a completed colostomy. The patient is ready for evacuation to the communication zone for further surgery. If,

however, extensive damage occurs to the bowel, a whole loop or more may be brought outside the abdomen to rest upon a sterile sulfanilamide vaseline gauze field. Thus the bowel may be watched if peritonitis and gangrene occurs, and, if not, it is repaired and replaced after evacuation to the U.K. or to a general hospital. Here wisdom is in waiting and watching, for too much haste and classical surgery are often the stepping stones to the icy grave. Postoperatively the patient is given daily intravenously saline 1000 cc., 5 or 10% glucose 2000 cc., and plasma 250 to 1000 cc. as required. Simultaneously a Levin tube, attached to an improvised Wangensteen apparatus is inserted into the stomach; remaining thus for four to six days. After three days, orally little water and tea are given, then gradually a liquid diet. If no distension occurs, the Levin tube is removed. All sutures, especially retention cat gut or black silk or cotton sutures, remain intact until the patient returns to the U.K.; regardless if sloughing occurs about the sutures. These sutures often remain intact for two or three weeks or more. This precaution is to prevent post operative herniation which may occur during evacuation. Ether oxygen proves to be the best anesthetic for abdominal surgery.

All pelvic injuries require that a retention catheter be inserted into the bladder. If the urinary bladder is injured, a suprapubic cystotomy is performed. So, catheters thus draining the bladder, the patient is transferred to the U.K. Incidentally, all casualties except abdominal are usually evacuated to the U.K. by air via the C-47 planes. All wounds of the rectum, colon, and bladder warrant a colostomy and retention catheters in the urinary bladder prior to evacuation.

Every chest casualty is first x-rayed for pulmonary pathology, fractures, hemorrhage and foreign bodies. The anesthesia preferred is sodium pentothal induction, then pressure ether oxygen supplementation. Fractured ribs are treated conservatively unless they have perforated the pulmonary cavity and lungs. Then the classical rib resection is used to permit removal of foreign bodies, rib fragments, and extravasated blood clots. Then lung lacerations are sutured with black silk or cat gut. If necessary a lobectomy is performed on the macerated lung. The pleura is tightly sutured, then the intercostal muscles and skin are well approximated with stay sutures. Previously, a water drain catheter is inserted into the posterior axillary lower pulmonary cavity; and closed under-water suction is maintained until recovery and the lung has been partly aerated before evacuation by air to the U.K. All original chest incisions are securely sutured air tight, and the water sealing draining catheter is placed in the dependent pulmonary cavity. Thus blood, serum, and purulent discharges may escape without causing a sloughing in the original site of entry into the chest. Closed pressure oxygen ether anesthesia is preferred, especially intratracheal.

All head injuries are primarily x-rayed to decipher foreign bodies, fractures, and other pathology. Then surgery is deferred for 24 to 48 hours. During this time the patient receives plasma, intravenous fluids, intravenous sodium sulfadiazine gm. V t.i.d., and penicillin 40000 U q. 4 hours. This period of waiting prepares the patient as a better risk for surgery, since shock is usually passed and the brain begins to function more adequately. Preanesthetic medication is usually morphine gr. ⅛ or ¼ with atropine gr. 1/150 or gr. 1/100 half hour before surgery. Then sodium pentothal, 2½% solution, is given intravenously for light general anesthesia. Locally 1% procaine is infiltrated beneath the scalp at the site of operation. Usually an airway is inserted into the patient's mouth for safety. Lacerations of the scalp are delicately cleaned and debrided; foreign bodies and loose bone are removed. By radial incisions, to preserve the normal circulation, the scalp is reflexed, the pericranium pushed aside and the necessary part of the skull removed to facilitate proper exploration, and to remove shell fragments and loose bone along with macerated brain. Small foreign bodies and torn brain tissue are easily removed by instilling a long blunt metal tube between the gyri or in the macerated brain area, then by forced saline irrigation through this tube; the area becomes surgically clean. Then sulfanilamide powder is dusted upon the brain and meninges. Bleeding having been checked by sealing wax, cautery, and silver clamps, the dura is sutured tightly. If the dura is destroyed, a muscle or fascia flap covers the brain. Then the scalp is sutured in layers. Blood and plasma transfusions are given as required. Patients are kept under pentothal anesthesia as long as five hours, consuming in toto about two grams or 60 cc. of a 2% solution. Rarely is oxygen necessary if the pentothal is given conservatively surgically; if the air passage is kept unobstructed; and if proper preanesthetic medication is given. Thus skull and brain injuries are shipped to the U.K. or U. S. A. by air evacuation, where weeks later a vanadium plate is laid over the missing part

of the skull. In case of extra dural hemorrhage, the dura is never incised.

Usually projectiles have a smaller, less jagged port of entrance than the larger more irregularly torn exit. Bullets usually have a more normal entrance and tend to follow fascial lines, especially if they are diverted by bone, which usually is fractured. Shrapnel, or, more accurately, fragments of high explosive shells, have an irregular perforation through the skin, but due to their speed and revolutions, clothing, etc., is forced beneath the skin; then due to continued revolutions, all tissue in their path is macerated, traumatized, and the fragments have tissue wounds about them like twine about a ball. These fragments cause much more damage than bullets, since the path of the fragment is complete trauma to all tissue and thus they are more difficult to locate, remove, and to prevent infection. These fragments cause early infection due to the trauma of local circulation, and the impossibility of drainage, thus inviting early gas gangrene. This is the reason why all battle wounds must be debrided or excised, and left wide open to permit free drainage; for one cannot estimate what extensive damage a fragment can produce. Thus all casualties are given sulfadiazine gm. I q.i.d. and pre and also post operatively as a safety measure. Thus the percentage of infection is almost zero. We try to aid nature to lick her wounds, and not destroy the natural healing powers by suturing up wounds so that infections shall predominate to fill the graves.

Just a brief summary of the chain of evacuation in the theater of operation. On the initial line of fire, treatment of the wounded is begun by company aid men, and collection of these casualties is by litter bearers, who bring their wounded to the Battalion Aid Station. Here emergency treatment is augmented and patients are sent to the Collecting Station by litter or ambulance. Now, casualties are sorted, further treated, and rechecked for evacuation by ambulance to the Clearing Stations. Treatment is supplemented, and casualties then are carried by ambulance to Evacuation Hospitals or Field Hospitals, with auxiliary surgical teams attached. Here definitive treatment is finished, in preparation to evacuation to the General Hospitals in the communication zone or to the U.K. or States, by ambulance, hospital trains, air evac. units of C-47 planes and by hospital ships.

Thus the chain of evacuation in the combat zone is emergency treatment by company aid men at the site of fire to Battalion Aid Station, to Collecting Station, to Clearing Station, to Field Hospital or Evacuation Hospital before a patient is fit for long trips to the U.K. or U. S. A.

The communication zone of evacuations commences after the patient is transferred from the Evacuation or Field Hospital to a General Hospital. This distance may be ten to fiteen miles from the front, and extends to the United Kingdom and to the seacoast of the United States. At every link of of this chain of evacuation, the casualty is examined, treated, made more comfortable and assured a safe, healthy return to duty or home. Incidentally, a medical record is kept on each patient, commencing at the battalion aid station, and is completed only at final discharge.

Thus, in conclusion, I finish writing; as I sit in my cold wet tent which is poorly illuminated by a flashlight, and listen to the blasting tune of neighboring 240 mm. artillery and that familiar hum of our P-47's overhead.

No greater sacrifice can a physician give to his country, than to leave the comforts of private practice, friends, and home to accept voluntarily the trials, sacrifices and disappointments of military life, in order to help insure the return of the wounded American soldier to his loved ones.

Paul P. Duzmati

## From Major A. B. Sundquist, AUS, Manchester

17 November 1944

Your letter of August 15 arrived today. I suppose your Army and Navy number has already gone to press. On the possibility that my experiences may prove of some interest to the boys at home, I'll write here a factual account and save the purely story elements for our society meetings.

From September 1942 to September 1943 I was stationed at an air base in Georgia. During nine months of this period I was senior medical officer or surgeon. I had a small detachment of medical and dental officers and enlisted men under me. Our principle job was getting men ready for overseas service. This was accomplished by eliminating the unfit, making dental corrections, giving necessary immunization and getting records in order. We also carried on a daily sick call, made sanitary inspections and periodic physical inspections.

In September 1943, a request for transfer to the ski troops in Colorado was granted. There my duties were those of medical inspector most of the time. I spent some time as commanding officer of a medical company until my promotion to Major came through when I was made a regimental surgeon. My eight or nine months in the Rockies were very enjoyable. In this beautiful country I was taught skiing and rock climbing and general mountaineering by some of the best men in the world in these fields. I was taught how to take care of myself in the mountains under conditions of extreme cold and at high altitudes. I loved it.

I was suddenly ordered into an Airborne outfit and sent overseas. I landed with a medical outfit in Southern France, behind the enemy lines on D day of that invasion, in a glider. For forty-eight hours the medical officers and enlisted men worked without sleep taking care of casualties. Then the beach head forces broke through to us and took the wounded off our hands. I'm not allowed to tell you any more except that I'm still airborne and wear my glider badge with perhaps a little more pride than is warranted.

I've tried to give you a factual account of my military experiences to date. On the whole it's been a Cooks tour with a few adventures en route. I'm saving the lies and tall tales for some of those priceless county meetings.

Regards to all the boys.

Al

## From Major B. J. Buck, AUS, Hartford

c/o Postmaster, San Francisco, Calif.,
29 November 1944

A couple weeks ago I received here in New Guinea your request for a letter of experiences.

We are a field unit and our first functioning as a hospital about 5 months ago was as a field hospital. We moved into this forward area and were told to set up a few hundred yards from the perimeter. Fortunately the Japs had no artillery and were at the far end of our area though a few sniper casualties occurred in line units very near us and occasionally a lone Jap was picked up. For several weeks we were between the "155's" and the perimeter so shells whizzed over our heads nearly daily and nearly always at night. We could feel the blast from the discharges and see the sides of the tent move.

Our first day of medical work was a real "Baptism." We had over half of our equipment off the ship and had been setting up for 4 days having up a hundred beds and were to get "a few simple" cases the fifth day.

The fifth day hell broke loose up front and we received nearly 200 battle casualties in 8 hours! All but two or us became surgeons and we two gave dozens of units of plasma and helped sort cases and make them comfortable. Everybody had a minimum of 2 to 4 hours sleep daily for 3 days. The men were given morphine and often plasma before they arrived. It was amazing to me the fortitude of those men! With open wounds, compound fractures, etc., there was scarcely a cry uttered or a complaint made or a request to take an individual first. I cannot but admire the average soldier.

Any case that would take over 3 weeks to convalesce was evacuated by air as soon as physical condition would permit. This method of evacuation is most valuable for these men.

Two weeks after we opened we had settled into routine operation. Battle casualties and camp accidents made up over half of our work and for about a month we ran at capacity. There were the usual number of "gold brick" backaches but it was a very satisfactory surgical service and well run by a very competent surgeon from Florida.

The medical service has always made up less than half the hospital—it is my particular care.

Of course we were most interested in the new diseases. We have had several hundred malaria cases—most of them new cases. Atabrine is a most satisfactory suppresser and if regularly taken is supposed to be 100%. We have seen a few apparent failures. Nearly half of our cases were P. falciparum infections and a couple had bizarre pictures but most have given no trouble. Vivax infections look sick with temps 104 to 106 but do beautifully. Any case who is vomiting or looks very acutely ill is given intravenous quinine and can usually take atabrine by mouth in 6 to 12 hours. We have had only 4 or 5 cases develop enough anemia or cerebral symptoms to require evacuation. We have been most fortunate having no malaria deaths.

Dengue is a harmless but uncomfortable disease diagnosed clinically—so is apt to be a scrap basket.

Typhus of the scrub type has been seen in a couple dozen cases. They are pretty sick but our mortality has been very low. We have routinely evacuated them in from 2 to 4 weeks during con-

valescence. Treatment is entirely symptomatic and supportive.

I have had to function as psychiatrist and neurologist and have learned a lot. We have had a number of psychoses—mostly manic depressive and dementia praecox. Psychoneuroses make up nearly a third of our medical cases and their predominant symptomatology is gastro intestinal. Though doing over 150 gastro intestinal x-rays we have seen only 4 ulcer cases. The indigestion is an anorexia, epigastric distress, often nausea, group of symptoms unrelated to meals or type of food. I suspect this replaces the "shell shock" of the last war as an expression of personal inadequacy. Also army diet in an area like this is not very inviting.

We have had two deaths from a peculiar blood dycrasia and known of several others. It is marked by purpura, low white count to below 1,000 with a few polys present, prolonged bleeding time and a complete failure to respond to transfusion. The usual name applied is aplastic anemia but it looks to me more like a destruction of bone marrow by some toxemia.

The only other group of particular interest is the skin cases—and we are fortunate in having a qualified dermatologist from Chicago. The non specific dermatoses do badly here and after repeated hospitalizations are usually evacuated. Most every one has some fungus infection and skin infection (impetigo and furunculosis) at some time but these respond well. This whole group is popularly known as "jungle rot." Then there have been a surprising number of cases of lichen planus which are not quite typical. These all have to be evacuated. Cause of these is unknown and causing much speculation.

We have had a very interesting experience but as a whole not too satisfactory as we have no follow up for end results. Also most of the time we are not busy enough. I should guess I have done 3 months of real work in the last year. However, one realizes the necessity of our being here.

Recently I saw but only to say hello to a former intern, Capt. Robert A. Sterrett who passed through with a fighter controls squadron. Six months ago I met Miss Nellie Rhabsky who was a nurse in the Crane Building—she is still working in EENT.

My best regards to my friends at Hartford Hospital and about home.

Burdette Buck

## From Henry R. O'Brien, Sen. Surg., USPHS, Hartford

Washington 25, D. C.,
December 9, 1944

As I sit here in the office and watch the lights of Washington, it is hard to realize that one month ago I was in a Greek refugee camp in Palestine watching it pick itself out from the wreck wrought by the first fall gale. I enjoyed that refugee work in the Middle East (though dealing with that first situation was something). One works with a mixture of R.A.M.C. doctors, refugee Greek and Yugo-Slav and Czech and Palestinian physicians, refugee girls who make fine nurse aids, registered nurses from at least four countries, and so on. One interesting discovery was a Yugo-Slav woman who had made dental fixtures back home, and was now making them for a camp of 25,000, many of them old people.

In Cairo I met a fellow member of the Connecticut Association, Dr. E. Calverly. She and her husband are at the School of Oriental Studies at the American University, in an attractive set of buildings. She asked me to ask you to be sure to send her JOURNAL to her.

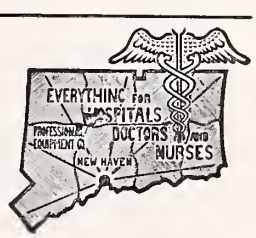
They had expected me to take over the medical responsibility for all our camps in the Middle East, when I was suddenly called back here, preparatory to going out to Australia, where I am to be the health representative in the new office to be opened there. We shall deal with affairs in South East Asia. It would be fine to have a glimpse of the people in the Yale unit.

The December JOURNAL has just reached me, and I am enjoying the letters from the other men a lot. This is a very real service. Continued power to you, and a fine Christmas.

Henry R. O'Brien




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## GOVERNOR BALDWIN DISCUSSES HEALTH IN INAUGURAL ADDRESS

In his inaugural address at the beginning of his third term on January 3, Governor Baldwin said:

"Connecticut has been unusually healthy during these past two years, in spite of long working hours, crowded living conditions, the scarcity of some customary and body building foods, shortened fuel rations and the absence of many of our physicians and nurses in the armed forces of our country. We have been under a tremendous strain, the evidences of which become increasingly apparent as time goes on. The last regular session of the General Assembly substantially increased the appropriations for the Health Department. That increase made it possible to do many necessary things in industrial hygiene, nutrition, maternal and infant care and for the prevention and gradual elimination of the so called social diseases. The experience of other wars indicates to us that we must always be on our our guard against epidemics.

"In all our health measures we must be constantly putting emphasis on preventive measures. Such a policy has produced marked results, for example, in the prevention, treatment and care of tuberculosis. We no longer have any waiting list for our sanatoria in spite of the fact that in these past two years we have intensified our efforts to find hidden cases and thus eradicate the disease. If other states did as well as we the 'white plague' would be in ultimate course of early extinction and would join scarlet fever, diphtheria and small pox, dread diseases that are now well controlled.

"We have three big hospitals for the mentally ill in Connecticut and two training schools for defective children. Two of them are of recent construction and the other three have been substantially enlarged within recent years. The time has come when we should take firm, positive steps for the prevention of mental illness of all kinds. We should build around the experience and personnel of our mental hospitals and our State Department of Health, working in collaboration with private agencies interested in this all important subject, a sound, progressive program for the protection of mental health and the prevention of mental illness and disease."

## COMMITTEES OF THE GENERAL ASSEMBLY

### Appropriations

Senators Malkan (Chm.), Egan, Hurley, Monnes, Fenn; Messrs. Campbell, (Chm.), West Hartford; Curtis, Bridgewater; O'Connor, Darien; Mrs. Keeney, Somers; Messrs. Andrews, North Haven; Carpenter, Canterbury; Casey, North Canaan; Mrs. Ryan, Ridgefield; Messrs. Beckwith, East Lyme; Eliot, Sr., Clinton; Farnham, South Windsor; Mrs. Stewart, New Canaan; Messrs. Hall, Milford; Davey, Winchester; Donnelly, Thompson; McMullen, East Haddam; Mahaney, Waterbury; Jenkins, Torrington.

### Judiciary

Senators RisCassi (Chm.), Coles, Damiani, Barber, Brock; Messrs. Wanderer (Chm.), Bethel; Shapiro, Farmington; Conway, Guilford; Burke, Greenwich; Koskoff, Plainville; Thim, Hamden; Stapleton, Cheshire; Hickey, Stamford; Hicks, New Canaan; Willsey, Wethersfield; Parmelee, Durham; Pruyn, Colebrook; Longley, Union; Sullivan, Enfield; Herman, Bridgeport.

### Public Health and Safety

Senators Lynch (Chm.), Scott, Spellman, Giampietro; Mrs. Wakelee (Chm.), Wolcott; Mr. Judson, Woodbury; Mrs. Griffin, Trumbull; Mr. Austin, Coventry; Mrs. Warner, Newington; Mrs. Stahlsburg, Saybrook; Miss Spaulding, Norfolk; Mr. Burke, Preston; Mrs. Prokop, Stratford; Messrs. Clark, Scotland; Pruyn, Colebrook; Baker, Woodstock; Cohen, Colchester; Smith, Danbury; Scully, Danbury.

### Public Welfare and Humane Institutions

Senators Hall (Chm.), Wallace, Hurley, Vincent; Mr. Lamb (Chm.), Plainville; Mrs. Griffin, Trumbull; Mrs. Edgerton, Stamford; Miss Nichols, Fairfield; Messrs. Field, Waterford; Hubbard, Haddam; Miss Little, Guilford; Miss Arrigoni, Durham; Messrs. Newett, Winchester; Skelly, Tolland; Goddard, Granby; Swan, Farmington; Maddox, Bethlehem; Mrs. Kline, Meriden; Mr. Swider, Salem.

# NEWS FROM WASHINGTON

## Recommendations of the Sub-Committee on Wartime Health and Education of the United States Senate

(The Pepper Committee)

On the basis of the preliminary findings, the sub-committee:

1. Recommends that Federal grants-in-aid to States be authorized now to assist in post war construction of hospitals, medical centers, and health centers, in accordance with integrated State plans approved by the United States Public Health Service.

2. Recommends that Federal loans and grants be made available to assist in post war provision of urban sewerage and water facilities, rural sanitation and water facilities, and milk pasteurization plants, in communities or areas where such facilities are lacking or inadequate.

3. Urges State and local governments to establish full time local public health departments in all communities as soon as the needed personnel become available. With this aim in view, consideration should be given to rearrangement and consolidation of local health jurisdictions and to amalgamation of existing full and part time local health departments with overlapping functions. The Federal Government should increase the amount of its grants to State health departments to the end that complete geographic coverage by full time local health departments may be achieved and that State and local public health programs may be expanded in acordance with needs.

4. Recommends that the Army consider the feasibility and advisability of expanding its program for induction and rehabilitation of men rejected because of physical and mental defects.

5. Recommends that the medical records of the Selective Service System be preserved and that funds be appropriated for further processing and study of these records.

6. Reports the acute shortage of personnel with training in psychology and psychiatry and the need for immediate steps to increase the output of such personnel with a view to providing child guidance and mental hygiene clinics on a far wider scale.

7. Recommends that Federal scholarships or loans be made available to assist qualified students desiring medical or dental education; urges that increased enrollment of women in medical and dental schools, and premedical and predental courses, be encouraged in every way possible.

8. Recommends that Federal funds be made available to States for medical care of all recipients of public assistance and that allotment formulas governing distribution of Federal funds to State public assistance programs be made more flexible in order to give more aid to States where needs are greatest.

The recommendations made above should be put into effect as soon as possible. We should begin planning now for the reconversion period. Further delay will postpone orderly solution of our health problems and deprive us of an effective means of aiding industry to maintain full production and employment after the war.

A comprehensive health and medical facilities program, planned now and undertaken as soon as materials and labor become available, would soon pay big dividends in improved national health and physical fitness. We have seen what neglect of opportunities for better health has cost us during this war. We should resolve now that never again, either in war or in peace, will the Nation be similarly handicapped.

## The New Congress

As the 78th Congress adjourned on December 19, there were growing signs that health insurance legislation will top the issues in the 79th Congress. During the past few weeks newspapers and magazines have given a great deal of space to discussion of Medical Care problems.

A Washington newspaper says "the most explosive single piece of domestic legislation before the incoming 79th Congress will be the Wagner-Murray-Dingell bill.

"This bill is a next session Administration 'must.' Reprints already have entered two editions. House and Senate document clerks report a run on for more. Inquiries at Congressmen's offices top calls on any other legislation."

Headlines in one newspaper say *Put Medical Care Second to Peace.*

### WILL REINTRODUCE BILL

Senators Wagner and Murray and Representative Dingell have stated that they will reintroduce their bill and daily in the Congressional Record there have

been demands for an early committee hearing. Senator Wagner is said to be very much peeved at the medical men, as is also Representative Dingell, for the opposition received from physicians during the recent election campaign.

The night before the election Mr. Dingell went on the radio to hit back. He charged a well financed campaign against the bill "by a group of medical mossbacks of the American Medical Association."

The bill was never called up for committee hearing in the 78th Congress and peacefully reposes in the committee's files. But the sponsors will undoubtedly exert increased energy in pressing their proposal in the new Congress.

*Reports say labor will sponsor eight or more state health insurance bills. It is said that Michigan and California have been singled out as the testing grounds.*

PEPPER MAY OFFER BILL

Questions propounded by Senator Pepper (Florida) during his subcommittee's hearing on the Nation's Wartime Health Program, indicate that he may offer a bill on this subject. Possibly providing for Federal grants to States for voluntary health care plans and hospital and clinical facilities. Obligations in Washington have made it impossible for Senator Pepper to conduct committee investigations on the west coast, as had been intimated some weeks ago.

There is talk of several bills on medical care, but this has not crystallized to the point where the probable authors are known at this time. There is also talk that the health insurance feature of the Wagner-Murray-Dingell bill will be separated from the other provisions.

Insiders here think there is not much possibility of passing a bill which will increase payroll deduction taxes, not even for medical care. They say 1943 was the best year for putting over such a measure. A straw in the wind may be the big vote in favor of freezing the Social Security tax at its present level, rather than doubling it. The President signed this bill "with reluctance" and announced that he would submit a plan for broadening the entire social security program.

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

The organizational meeting of the Fairfield County Woman's Auxiliary was held at a luncheon meeting at Stratfield Hotel, Bridgeport, January 18. Guest speakers were Mrs. H. Bertram Lambert, president of the state auxiliary, Mrs. Creighton Barked, vice-president in charge of organization, and Don J. Knwolton, president of Fairfield County Medical Association.

The nominating committee of the State Auxiliary met at the office of the State Medical Society, New Haven, on January 15. Mrs. Fredercik W. Wersebe of Washington is chairman of this committee.

The first board meeting of the Hartford County Auxiliary was held on January 19, at the Hunt Memorial Building. Mrs. Arthur B. Landry presided. Officers and chairmen of standing committees discussed business on hand.

Mrs. Charles W. Goff, Secretary

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Figures published in Washington state that 20 million persons—approximately one-fourth of the Nation's adult population—will be eligible for medical care provided by the Government, when peace comes.

HEALTH INSURANCE DIRECTOR PROPOSED

The *Washington Post* of December 5 says: "The American Medical Association's Council on Medical Service and Public Relations yesterday urged the creation of a Government agency to administer a Nationwide program of health insurance and prepaid medical care.

"The recommendation came at the close of a three day conference of the council at the Mayflower Hotel.

"The conference suggested that a medical man be appointed to head the proposed bureau and be given the status of a Cabinet officer. 'Director of Health Insurance' was tentatively proposed as a title accurately describing the duties of the office."




THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

## Pregnancy Plan

The following Pregnancy Plan for Women in Industry was suggested by Caroline G. Olsen, R.N., and published in *Industrial Medicine* (August 1944):

THE PLAN

To All Women Employees Who Are Now Married Or Who May Become Married During Their Employment With Us:

Dr. ——— in charge of our Medical Department, requests that each woman employee report promptly to the First Aid Department in the event of pregnancy.

You may continue working as long as it is considered safe by your family doctor, or by the doctor at the health agency or clinic to whom you report for care. A statement to that effect is required from your physician immediately in order that Management can cooperate with you and the Medical Department can cooperate with your personal physician to safeguard your health and the health of your child.

PROCEDURE IN EXECUTING PREGNANCY PLAN

1. The Pregnancy Plan inserted in an envelope and marked PERSONAL is distributed to all women upon employment and by the use of a payroll insert to women already employed in the plant.

2. Management may arrange for the plant doctor to create an educational program and distribute instructions for following it to the women.

3. At the time the employee reports her pregnancy she is instructed to report to plant first aid periodically that they may be assured she is consulting her family physician. To promote the prompt reporting of pregnancy, it must be realized by both management and employee that the greatest benefits shall be derived from a leave of absence, not from a discharge.

4. An initial inspection of the woman's work is imperative in order that adjustments may be made if necessary. Periodic checks of the conditions of her work should follow.

5. The plant physician or the nurse should notify the family doctor or clinic if any evidence of irregularities occur at her work.

6. The recommendation for the termination of employment may be made by the plant physician or the family doctor.

## Addiction to Demerol

In the Bulletin of the *Menninger Clinic* (July 1944) is published the first report in this country of a case of spontaneous addiction to demerol. It is believed to be the second case of this kind in the literature.

## Ascorbic Acid in Canned Citrus Juices

Interesting figures on the retention of ascorbic acid in canned fruit juices are submitted by *Nutrition Reviews*. Canned grapefruit, orange, pineapple, and apple juice were tested and the ascorbic acid contents found to be for grapefruit 29.9, orange 34.6, pineapple 9.8, and apple 1.7 mg. per 100 ml. After a day of refrigeration the average loss of ascorbic acid from the freshly opened cans was 3.0 per cent for grapefruit, 3.7 per cent for orange, 1.1 per cent for pineapple, and 24.1 per cent for apple juice. In three days of refrigeration the loss from grapefruit juice was only 5.6 per cent. The losses were the same whether the juice was stored in the open can or in a covered glass jar.

## Red Cross Ships Penicillin by Air For Prisoners of War in Germany

On the basis of recommendations by medical officers recently repatriated from German prison camps and hospitals, the American Red Cross has sent 5,000 tubes of penicillin by air express to the International Red Cross Committee in Geneva to be used for American prisoners of war held by Germany.

The Red Cross plans additional shipments of medicines and medical supplies for prisoners of war in the light of the repatriates' reports. The International Committee has been asked to keep the prison camp leaders informed of the medicines available in the stocks held in Geneva for their use, and to suggest that the leaders not allow camp stocks to become depleted before reordering.

Regular shipments of Red Cross first aid kits intended for use when doctors are not available have been made to the prison camps in Germany. Bulk shipments of medicines and medical supplies also have been made to supplement those provided by German military authorities for the care of sick and wounded prisoners of war.

# SPECIAL NOTICES

## NATIONAL CONFERENCE ON MEDICAL SERVICE

Sunday, February 11, 1945

Red Lacquer Room, Palmer House, Chicago

"Post War Distribution of Medical Care"

(Conference Theme)

(More time than usual has been set aside for questions and informal discussion. All who attend are urged to participate.)

9:00 A.M. Registration, 4th floor, at entrance of Red Lacquer Room.

9:30-9:50 A.M. President's Address, "Medicine and the National Crisis," C. L. Palmer, M.D., Pittsburgh.

9:50-10:20 A.M. "What Labor Expects from Medicine," Walter Reuther, Vice President, United Auto Workers, CIO, Detroit.

10:20-10:50 A.M. "What the Farmer Expects from Medicine," Roger C. Corbett, PH.D., Secretary, American Farm Bureau, Chicago.

10:50-11:20 A.M. "What the Insurance Man Expects from Medicine," Harlan S. Don Carlos, Manager, Life, Accident and Group Claim Department, The Travelers Insurance Company, Hartford, Connecticut.

11:20-12:00 NOON. Open Discussion.

12:00-1:45 P.M. Luncheon (War time regulations make it impossible for hotels to serve Sunday luncheon for conference. Regular dining-room facilities of hotel will be available.)

1:45-2:15 P.M. "The Miller Bills and Medical Legislation by Congress," The Honorable A. L. Miller, Washington, D. C., Congressman from Fourth District, Nebraska.

2:15-2:30 P.M. Questions and Answers.

2:30-3:00 P.M. "Public Relations Program of the American Medical Association," John Fitzgibbon, M.D., Chairman of the Council on Medical Service and Public Relations, A.M.A., Portland, Oregon, or Alfred W. Adson, M.D., member of Council, Rochester, Minn.

3:00-3:20 P.M. "Future Trends in Medical Practice," Lt. Col. Harold C. Lueth, M.C., Liaison Officer, Surgeon General and A.M.A., Chicago.

3:20-3:40 P.M. Discussion.

3:40 P.M. Prepayment Medical Insurance Plans. Service vs. Indemnity Type of Insurance. (Open discussion.) Moderator—Creighton Barker, M.D., Secretary, Connecticut State Medical Association, New Haven.

## THE BEAUMONT MEMORIAL FOUNDATION

Organization of the Dr. William Beaumont Memorial Foundation is announced in a handsome brochure now available to members of the profession. The home of the foundation is at Prairie Du Chien, Wisconsin, where Dr. Beaumont carried on many of his history making experiments. It is housed in a restoration of the old Fort Crawford Military Hospital.

The Foundation was organized as a memorial to the pioneer physiologist and as an American medical shrine. It is sponsored by a group of eminent medical men and community minded Wisconsin citizens.

Officers and directors are: M. J. Dyrud, President; Dr. O. E. Satter, Vice President; Dr. T. F. Farrell, Treasurer; J. A. Dru'yor, Secretary; Cal Peters, Curator, Medical Advisors are: Dr. P. L. Scanlon, Dr. H. H. Kleinpell, Dr. J. J. Kane, Dr. C. A. Armstrong, Dr. E. H. Lechtenberg and Dr. E. M. Dessloch. Directors: Dr. W. D. Stoval, Chairman of the Board, Dr. O. E. Satter, Dr. T. F. Farrell, Mayor F. W. Clanton, Mr. P. H. Schmidt, F. A. Otto and M. J. Dyrud.

Advisory Board: Dr. Walter J. Meek, Chairman. Members: Dr. Arno B. Luckhardt, Dr. Walter B. Cannon, Prof. Ben Elliott and Dr. Edward P. Alexander.

The announcement brochure gives an interesting history of Beaumont, the New England boy whose backwoods research and observations laid the ground work of modern physiological science. It carries many excerpts from Dr. Beaumont's diaries as well as his famous "51 Inferences."

Medical men may secure a copy of the booklet by writing the Dr. William Beamont Memorial Foundation, Prairie Du Chien, Wisconsin.

## SPRING REFRESHER COURSE IN OTOLARYNGOLOGY

The fifth semi-annual refresher course in laryngology, rhinology and otology will be conducted by the University of Illinois, College of Medicine, at the College in Chicago, March 26 to 31, inclusive. While the course will be largely didactic, some clinical instruction will be included. This course is intended primarily for ear, nose and throat specialists. As the registration is limited to thirty, applications will be considered in the order in which they are received. The fee is $50. When writing for application please give details concerning school and year of graduation, and past training and experience.

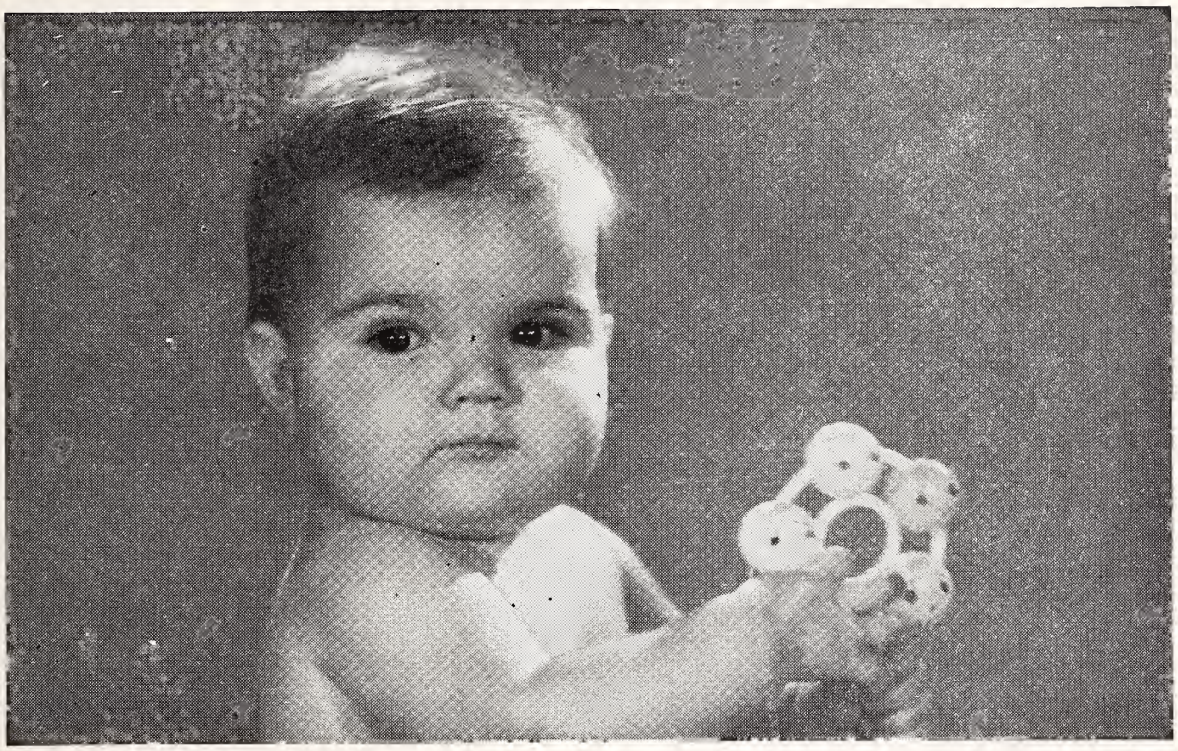
Address: Dr. A. R. Hollender, Chairman, Refresher Course Committee, Department of Otolaryngology, University of Illinois, College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

## GENERAL ROTATING INTERNSHIP

### House Staff Appointments

To fill twelve places on the General Rotating Service.

Eight interns to begin July 1, 1945; August 1, 1945; September 1, 1945; October 1, 1945.



# WAR BOND MAN

## — CLASS OF '63

**Someday you'll want** to see that boy, or girl, of yours off to college . . . and *right now* is not too early to start making plans.

Maybe your youngster, like so many other American boys, will work his way through school . . . but even in that case you'll want to be in a position to give him a little help if he needs it.

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But take your dollars out of the fight—and you will be hurting yourself, your boy's future, and your country.

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**For every three dollars** you invest today, you get *four dollars back when your Bonds come due.*

For Nine Months Internship. One half of the number appointed may be permitted to continue for another Nine Months as Junior Residents, and thereafter, one-half of the number of Junior Residents may be continued for another Nine Months as Senior Residents, in accordance with the Allocation Plan of the Procurement and Assignment Service.

Internes Rotating Schedules Include as Many of the Following Medical and Surgical Services as is Possible Within the Term of Nine Months.

| | |
|---|---|
| Surgery | Medicine |
| Urology | Pediatrics |
| Proctology | Neuro-Psychiatry |
| Gynecology | Dermatology |
| Obstetrics | Pathology |
| Ophthalmology | Chemistry |
| Otolaryngology | Bacteriology |
| Orthopedic Surgery | Radiology |
| Neuro-Surgery | Physical Therapy |
| Anesthesia | |

The Hospital provides maintenance, uniforms, and a stipend of $25 a month.

The Hospital is approved by the American Medical Association for general internships and residencies, and by the American College of Surgeons as meeting its standards.

The Hospital occupies a block facing Madison Avenue, New York City. It is a modern, general hospital with a capacity of 362 beds for acute diseases, including 60 beds in its County Branch.

The Hospital for Joint Diseases is a General Hospital featuring Orthopedic Surgery.

About 6,000 patients are treated annually, and one-half of that number are in the surgical, medical, pediatric, and all of the above specialties. About seventy per cent of all patients are on ward service. All services are active.

The Out-Patient Department treats about 700 patients daily.

Graduating students and graduates of Class A medical schools are eligible.

Interns and junior residents after completion of their service are eligible for appointment as residents in orthopedic surgery.

Applications should be addressed to: Director, Hospital for Joint Diseases, 1919 Madison Avenue, New York 35, N. Y.

# OUR NEIGHBORS

## New York

Subscribers to the Associated Hospital Service of New York are now entitled to receive hospital care during a period of twenty-one days for each separate illness they may suffer instead of twenty-one days a year, it was announced on December 1 by Louis H. Pink, president of the organization. The policy of 90 additional days of hospital care at one half the regular hospital rate will remain in effect for each period of hospitalization.

William Worthington Herrick, professor of clinical medicine at the College of Physicians and Surgeons, Columbia University, a graduate of the Yale University School of Medicine in 1905, was elected, on the evening of December 7, president of The New York Academy of Medicine for a term of two years.

Beginning with the issue of January 5, the *Journal of the Medical Society of the County of New York* will appear on the fifth and twentieth of each month instead of weekly and will bear the title *New York Medicine*.

The recently noted rise in the venereal disease rate in New York City is particularly noticeable among teen-aged young people, according to a report of Health Commissioner Ernest L. Stebbins this week. He said that 645 new cases of syphliis had been reported among children between the ages of 15 and 19 between January and October of 1944. Last year the number was 212. New gonorrhea cases in this age group were 2,364 as compared with 1,897 in the same period last year and 990 in 1941. Other age groups showed a rise, but it was proportionately smaller.

# NEWS
## *from County Associations*

## Fairfield

The annual banquet of The Bridgeport Medical Society was held on Wednesday, January 10, at The University Club in Bridgeport. The following slate of officers was installed to serve for the ensuing year: President, Joseph F. Watts; President-Elect, George B. Garlick; Vice-President, Charles W. Nichols; Treasurer, James P. Walsh; Secretary, Edwin R. Connors.

## Hartford

The annual meeting of the Hartford Medical Society was held at the Hunt Memorial on January 2. The following officers were elected for the ensuing year: N. Herbert Bailey, president; Clinton



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*President*

## RECENTLY OPENED IN BRIDGEPORT

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## Litchfield

HEADS AFRICAN SOCIETY

From Mrs. Royal A. Meyers of Watertown we learn that her husband Major Meyers is a flight surgeon in Africa. She said, "He has been stationed on the Gold Coast in Africa for the past eight months where he has established and is head of a new medical society there. This society includes African, British and American doctors in the area and is called the African Anglo-American Medical Society. It has been very enthusiastically received and supported and is doing quite a bit to promote interest in the methods and experiences of the doctors from the various countries."

Major Meyers has been in active service since November 1, 1941.

## New Haven

At the regular meeting of the New Haven Medical Society, new officers elected for the coming year of 1945 were: Eugene M. Blake, presdient; Harry Berman, vice-president; Ralph Nichols, financial secretary; Hyman Levin, chairman of literary committee; Clement Batelli, recording secretary.

William O'Connell of West Haven has recently left for the United States Navy, having served in the Army in the first World War.

Lieutenant Colonel James C. Fox recently visited his family after having served in New Zealand with the Yale Unit for two and one half years. He is now being reassigned to a new station in the United States.

Michael D'Amico is reported to be on his way back from New Zealand to visit his family for a thirty day furlough.

There were seven new members admitted to the New Haven Medical Society during the year 1944.

Arnold Gesell of New Haven is the author of "The Role of Developmental Diagnosis in Clinical Medicine" which appeared in the *New York State Journal of Medicine*, issue of December 1, 1944. Dr. Gesell is director of the clinic of child development at Yale University and presented the manuscript above referred to before the annual meeting of the Medical Society of the State of New York last May.

John P. Peters of New Haven is the author of "The Effect of Starvation on Diabetes Insipidus" published in the *Journal of the A. M. A.* December 16, 1944.

## Windham

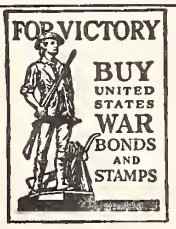
A campaign which has for its objective funds to replace a wing of the Day-Kimball Hospital in Putnam is progressing quite satisfactorily. More than three quarters of the objective has been subscribed, with the campaign still open. This will fulfill a need long felt necessary by both the hospital and the staff.

Lieutenant Commander J. A. LaPalm of Putnam has been transferred and is now stationed at the Sea-Bee camp in Davisville, Rhode Island.

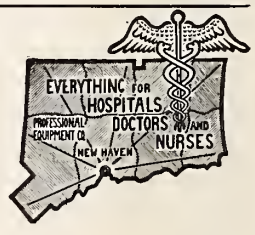
Captain R. E. Shea, Willimantic, who has recently been promoted, is still in India. He has had an attack of malaria but has recovered and is now with the Air Force in India.

# News from Yale University School of Medicine

One of the foremost medical historians of our time, Arturo Castiglioni, was honored recently on his 70th birthday by Yale University School of




AFTER HITLER'S FUNERAL — you medical draftees and volunteers will want a new, modern office. Why not let us issue you a credit to apply on your post-war medical equipment and furniture? When Uncle Sam calls, ask us for the details of our liberal credit-balance plan, or for our cash proposition. Turn over to us the headache of disposing of your present equipment! Professional Equipment Co., 36 Howe Street, New, Haven, Conn.




(SEE PAGE 2)




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*Literature on request*






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Medicine. Himself a student, Dr. Castiglioni has mingled with the students of the Yale School for the past four years "on a basis of ease and complete equality," to quote the *Yale Journal of Biology and Medicine*.

# NEW BOOKS IN REVIEW

*INTERNS HANDBOOK: A GUIDE, ESPECIALLY IN EMERGENCIES, FOR THE INTERN AND THE PHYSICIAN IN GENERAL PRACTICE.* (Third Edition.) By Members of the Faculty of the College of Medicine, Syracuse University, under the direction of *M. S. Dooley*, A.B., M.D., Professor of Pharmacology, and *Maynard E. Holmes*, M.D., F.A.C.P., Professor of Clinical Medicine, Co-Chairmen, Publication Committee. *Philadelphia: J. B. Lippincott Company.* 549 pp. 1944. $3.00.

Reviewed by JOHN T. BEEBE

The "Interns Handbook" is intended to be a concise pocket edition of every conceivable medical problem that might arise to confront an unsuspecting and "unprepared" intern. The accelerated medical school curriculum is undoubtedly ill preparing medical students to meet any medical situation whether of an emergency nature or not. This lowering of the standards of medicine is taxing the depleted staffs of all hospitals in their efforts to supervise these new interns. The patients, therefore, are in a position to suffer from either the omission of a necessary form of therapy or the commission of a deleterious form of therapy.

The authors have not proposed that this handbook is the answer, but imply that it can be used as a stop-gap in an emergency, or for other less pressing problems as a quick source of reference where literary facilities or supervision are not available. They have fulfilled their intentions for, in a little over 500 pages, they have compressed much of the pertinent information relevant to the practice of medicine. This is grouped under the following categories: (1) Medicine and Social Service; (2) Medical Jurisprudence; (3) Laboratory Medicine; (4) Medicine; (5) Surgery, including anesthesiology; and (6) Therapy.

Of necessity each topic is limited in scope and in some instances merely giving the briefest outline. This is of merit especially in emergency situations. The rest of the text comprises a very complete digest of the more recent trends in all the various fields of medical science. In this respect it is commendable only in that a brief survey of the highlights of each subject is brought into focus, but this is the chief objection to this type of literature.

Any topic of medicine which pertains to therapy must be rationalized as to cause and effect. In the majority of instances there is no need of hastily formed opinions. The interns of today are lacking background and experience. They, therefore, cannot be expected to practice intelligent and sound medicine by cook book methods. There is practically no Class A hospital in the country that does not have a medical library. There is not better experience for an intern than to learn how to obtain necessary information from current and past medical material in such a library. It is the only way in which he can achieve independence of thought and broaden his scope in medical knowledge. The intern is not mature enough to be entitled to use short cuts and, for this reason, he should not be encouraged to carry his brains in his pants pocket.

The second objection to the "Interns Handbook" is the fact that it cannot possibly include all the various procedures which are carried out in each hospital. Many hospitals have their own interns' manuals outlining the procedures of each department. Each of these differs with each hospital. It would seem more expedient for the intern to learn one procedure rather than to be confused by divergent methods.

In all fairness to the authors and the book it should be stated that there is a definite place for such a digest of medicine and specifically this is in the small community hospitals where equally good sources of information are not available.

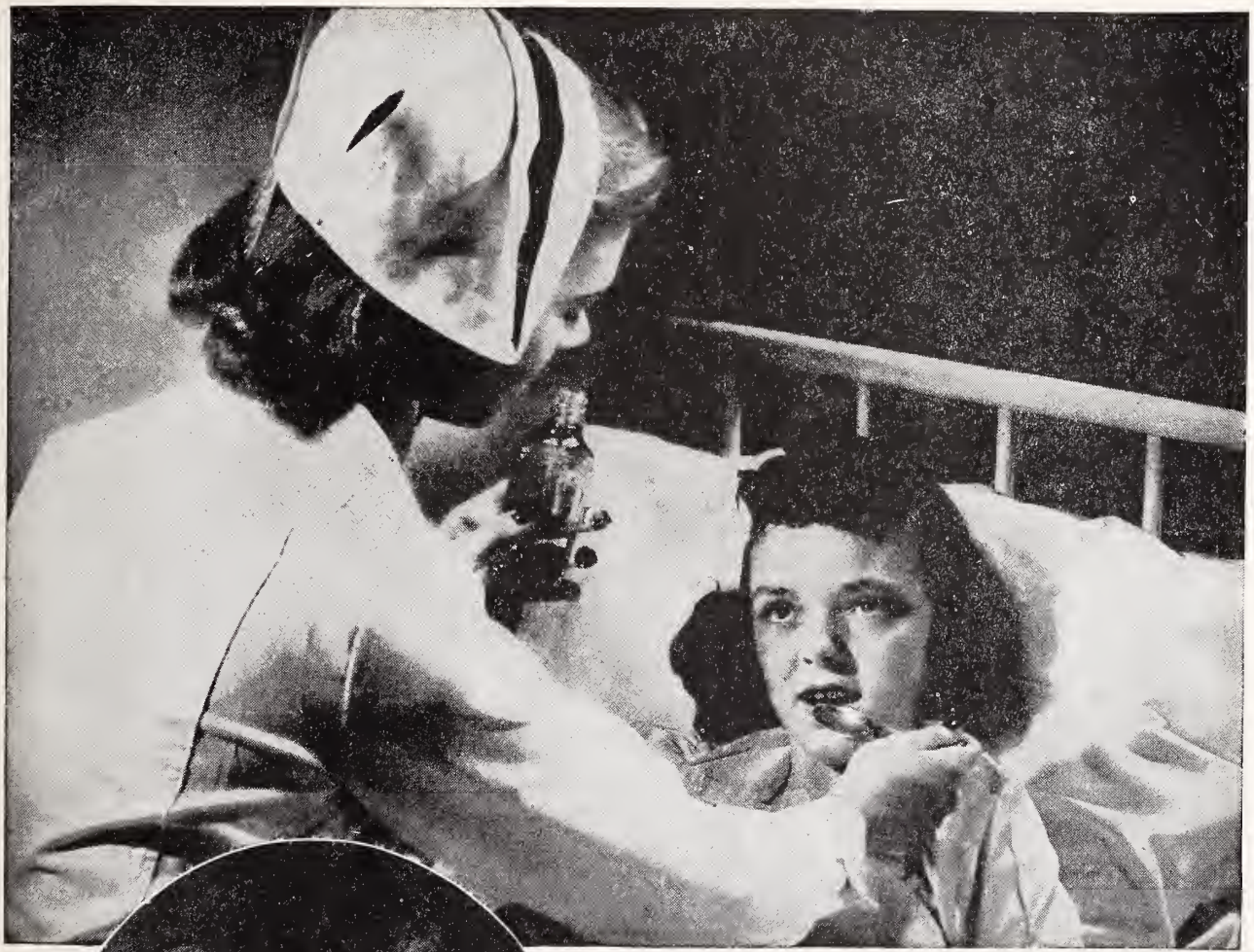
The "Interns Handbook" has no value in the armamentarium of the the modern house officer, in the well equipped hospital, except in as it may imbue confidence in meeting emergencies. The space devoted to these contingencies, however, is only a small fraction of the whole volume and could, therefore, be more readily useful to the intern if incorporated as such, thus permitting him the opportunity to seek further information from other sources. The major part of the clinical experience in hospital practice does not come under the sphere of emergencies. This experience, therefore, can find its ideal fulfillment only after thorough consideration of the patient and his disease. The intern assimilates best by digesting his own material rather than having it predigested for him.

*AESCULAPIUS IN LATIN AMERICA. By Aristides A. Moll*, PH.D., Secretary-Editor of the Pan American Sanitary Bureau, Washintgon, D. C. *Philadelphia and London: W. B. Saunders Company.* 639 pp. 1944. $7.00.

Reviewed by STANLEY B. WELD

"Aesculapius in Latin America" is a cyclopedic presentation of the development of medicine and its maintenance in Central and South America. For the most part the volume is better suited for reference reading than for the relaxation which interesting narrative affords one, although there are some chapters such as those marking the outstanding developments in the conquest of yellow fever and malaria, in the development of social security and in the growth of the new hospitals which are interesting.

This volume is profusely illustrated with reproductions of many old cuts and photographs of old, as well as new, hospitals and of the many leaders in medicine and public health in the various Latin American countries. There is appended a chronology for disease, a medical and general chronology for Latin America, a bibliography divided into countries, an index of names, and a subject index. In this day of increasing interest in our Latin American neighbors such a volume is a valuable addition to any large, rather than private, medical library. One feels in reading it, however, that there is much more of a story of the development of modern social and economic medicine in the South American republics which is only barely touched upon by Dr. Moll.





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*VOLUNTARY MEDICAL INSURANCE IN THE UNITED STATES: MAJOR TRENDS AND CURRENT PROBLEMS. By Helen Hershfield Avnet.* New York, Medical Administration Service, Inc. 107 pp. $1.00.

Reviewed by STANLEY B. WELD

Group Health Cooperative, Incorporated, of New York, a non profit medical insurance plan, operating in the southeastern counties of that state, in this volume presents a factual survey of the various voluntary medical insurance plans made by Medical Administration Service. This volume includes the historical development of voluntary medical insurance, a description of the various type of plans now in operation and a separate description of plans operating in New York City. In its summary attention is called to the problem confronting Blue Cross Plans which include in hospital services such physician's services as diagnostic x-ray, physiotherapy and anesthesia. The summary contains a plea for group practice plans which are held up as the solution of today's medical problems. Attention is called to the statement that it is apparently more feasible to offer comprehensive coverage under group practice arrangements than under a fee for service panel or straight cash indemnity plan. There is a question still whether all would agree with this statement.

Like other similar volumes dealing with a rapidly developing field this one does not include the developed and incorporated plans of 1944 such as the New Hampshire Plan.

*FOUNDATIONS OF NEUROPSYCHIATRY.* (Third Revised and Enlarged Edition of the Work formerly known as A Preface to Nervous Disease.) *By Stanley Cobb,* A.B., M.D., Bullard Professor of Neuropathology, Harvard Medical School, Psychiatrist in Chief Massachusetts General Hospital. *Baltimore: The Williams & Wilkins Company.* A William Wood Book. 1944. $2.50.

Reviewed by C. C. BURLINGAME

This is the third edition of a book well known to all workers in neuropsychiatry. It is always a pleasure to read the books of Dr. Stanley Cobb whose exceptional erudition and sparkling new ideas make increasingly attractive the study of nervous and mental activities for everyone, the hesitating novice as well as the confirmed specialist.

In this revised and enlarged edition the reader will find the most recent and essential information concerning the autonomic nervous system; segmental and suprasegmental aspects of the cerebrospinal nervous system; motor integration and locomotion; functional localization in the cerebral cortex; "consciousness" and the "mind-body" problem; "cerebral circulation;" cerebrospinal fluid; general neuropathology; the peripheral nerves and neuritis; special neuropathology; epilepsy; psychopathology.

There has been added a new chapter concerning "Some Psychological Concepts Important in Medicine." In it the author tries to conciliate the viewpoints of different schools of thought, the "anger shown by some experimental psychologists toward earnest workers . . . in psychoanalysis and . . . disgust expressed by some psychoanalysts toward their academic colleagues who . . . 'are learning more and more about less and less by ever fancier techniques.'" He suggests

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that psychoanalysis and the studies of learning processes should be closely allied fields as they both study the development of the personality from infancy. He reviews some of our knowledge regarding the instincts, showing how a training in the simple biology of barnyard and forest may be useful for a psychiatrist. Intelligence and special abilities; reason; intuition; fantasies and dreams are some other topics of this chapter. Here, too, is a study of the "rate of activity" illustrated by colorful personal observations made on sixty men from all branches of arts and science and all countries gathered at Harvard's Tercentenary celebration and forming a good sample of "what is recognized today as academic success." Most of these men had boundless energy, vitality and enthusiasm for their work, all had plenty of "spark." This energetic character seems to go with a bright eye, quick reaction time, upright carriage, and euphoric mood.

This chapter is a welcome addition to the book.

*AN INTRODUCTION TO PUBLIC HEALTH.* (Second Edition.) *By Harry S. Mustard,* B.S., M.D., LL.D., Director and Professor of Public Health Practice, Delamar Institute of Public Health, College of Physicians and Surgeons, Columbia University, New York City, New York. *New York: The Macmillan Company.* 1944. 283 pp. $3.25.

Reviewed by PHILIP E. NELBACH

Writing a "Baedeker" for a broad field of social art and science is not an easy task, and Dr. Mustard has done an excellent job for the audience he has selected. His treatment is designed to meet the needs of the senior college undergraduate who is interested in community hygiene or who intends to enter the fields of medicine or nursing. The practicing physician will also find it of value.

Serious study of this text by all premedical and nursing students would be an excellent step preliminary to their immersion in the multitudinously detailed technics of recognizing and treating diseases. Later, during the clinical period of training when the student is developing ability to penetrate beyond treating symptoms and diseases to treating the patient, would be the time to re-introduce him to the forces in the community which lead the patient and groups of patients to act as they do and which bear upon the physician himself and his relationship with his patients. Probably the most successful means of implanting this ability to reason concretely and usefully on social problems is through the case-work-seminar-project method. The student should leave the neat and ordered hospital and, as Dr. Mustard suggests, go out and get his feet dirty. He will find that the pattern of mental exercise involved differs from that used in learning intricate technics and hoarding facts. The text to inspire and guide such a procedure has not yet been written, but Dr. Mustard's book indicates the need.

For the student of public health administration this book would make interesting supplementary reading, but the introduction to public health should take place earlier.

The choice of chapters merits praise, including two on industrial hygiene and medical care which were not presented in the first edition, and good judgment is shown in proportioning the length of these various divisions. The chapter on vital statistics as tools for public health planning is strong and progressive. Perhaps the discussion of labora-

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tory technics which runs through the text of various sections might be raised to the dignity of chapter rank. It seems difficult to bring to people a realization of the multitude of activities beyond investigation of throat swabs and blood specimens in which the public health laboratory is engaged. In the control of food, milk, water, sewage, insects, air, and industrial poisons and hazards, laboratory technics have contributed substantially to epidemiological procedures and preventive sanitation.

In considering details, one might wish that the historical development included mention of the contributions of Galen and of Chadwick, that more optimism were indicated for rapid treatment of syphilis, and that a more definite program were proposed in the summary on medical care. The potentialities of mental hygiene work are well presented in the section on mental diseases which appears under the rather negative classification of non communicable disease.

One might like in future to see tuberculosis, mental disease, cancer, syphilis, heart disease, and perhaps polio grouped under a heading, Diseases of Great Expense (to the individual). Real strides in the control of these diseases are furthered when the community appreciates fully that the cost of treatment exceeds the individual resources of almost all persons so afflicted. When more rapid and effective means of treatment or immunization are perfected, as perhaps with syphilis, tuberculosis and certain types of mental disorders, these illnesses may one by one be promoted to the clasification, Preventable Diseases, as realistic optimism indicates.

Due to limitations imposed by need for brevity and by editorship to fit customary medical interest, the public health engineer will be disappointed in the restricted attention given to problems of environmental sanitation. Promotion of sanitary methods in food dispensing and manufacturing establishments is barely mentioned, and housing is touched on in three paragraphs.

*A BIBLIOGRAPHY OF AVIATION MEDICINE SUPPLEMENT. By Phebe Margaret Hoff, Ebbe Curtis Hoff and John Farquhar Fulton.* Published by the Committee on Aviation Medicine, Division of Medical Sciences, National Research Council, Acting for the Committee on Medical Research, Office of Scientific Research and Development, Washington, D. C. *Menasha, Wisconsin: George Banta Publishing Co.* 1944. 109 pp.

Reviewed by STANLEY B. WELD

Two years ago two of the three authors of the Supplement produced the first bibliography of aviation medical literature. As the present authors point out, during the two years which have elapsed the literature on the subject has expanded at a rate proportionate to the phenomenal growth of our air strength and the ever increasing importance of air warfare in combined military strategy. As in the case of the original Bibliography, the Supplement contains an index classified by authors as well as one classified by titles. To aid the research worker, existing literature is assembled in such a way as to bring to light relationships of material not previously obvious. In so doing the authors hope to stimulate new work.

The literature of the past two years in the field of aviation medicine indicates an emphasis on practical problems. This is evident in the amount of material published on techniques of survival and self preservation at sea and under arctic or jungle conditions. For this the Supplement has made allowance. Visual problems, accidents, psychological hazards, and rehabilitation all show an increasing interest.

A few minor changes from the original Bibliography appear in the Supplement. New publications in both journal and book form have been utilized as source material. One of the authors has been privileged to continue his work of collaboration after being commissioned in the Medical Corps United States Naval Reserve. The volume will be of increasing value as the war progresses and, together with sister volumes, should form an extremely valuable guide to the literature of this new and essential branch of military medicine. The Supplement appears as Publication No. 9 of the Historical Library of the Yale Medical Library.

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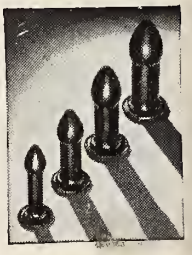
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*ABER'S DICTIONARY OF GYNECOLOGY AND OBSTETRICS. By Clarence Wilbur Taber*, medical editor, and author of Taber's Cyclopedic Medical Dictionary, Taber's Condensed Medical Dictionary, and Dictionary of Food and Nutrition, etc. With the Collaboraiton of *Mario A. Castalla*, M.D., F.A.C.S., Assistant Professor of Obstetrics, Jefferson Medical College; Gynecologist to St. Mary's and St. Agnes' Hospitals; Obstetrician to St. Mary's Hospital; Diplomate, American Board of Obstetrics and Gynecology, etc., etc. *Philadelphia: F. A. Davis Company*. 1944. 719 pp. $3.50.

Reviewed by STANLEY B. WELD

For the medical student, the obstetrical nurse, or the novice orking with obstetrical and gynecological terms, this volume ıay well be very useful. The author terms it a specialized ıedical dictionary. It might well serve its purpose for the ɔecialist wishing to verify his definition or pronunciation of term in the field of obstetrics and gynecology.

Like all Taber's dictionaries, it is published in a handy ɔrm. This volume is a subject dictionary as, in the words of ıe authors, "many of the definitions are cyclopedic and some f the subjects are treated at considerable length." Many llied medical words have been included as well as some rocedures used in general nursing of particular value to the bstetrical or gynecological nurse. Sub topics are listed one nder the other in alphabetical order. "See–see" definitions ave been eliminated. A fact finding index is included with ode markings to indicate where described. Also there is urnished a list of the principal medical abbreviations. The olume is well illustrated.

## J. S. Drug Companies vs. Axis Companies

*The Journal of Commerce*, New York, reports hat American drug, pharmaceutical and medicinal ompanies are engaged in an intensive effort to btain a larger share of the Latin American markets, ormerly dominated by Axis interests. They are letermined to hold these markets after the war, and s part of the program are organizing new companies n Latin American countries, also expanding subidiaries previously established there.

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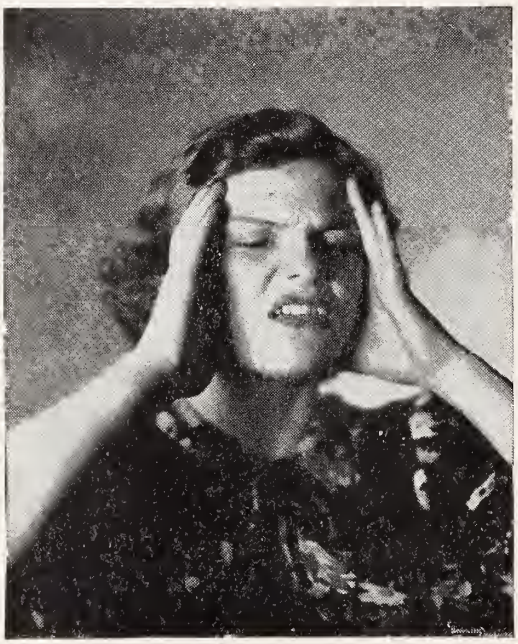
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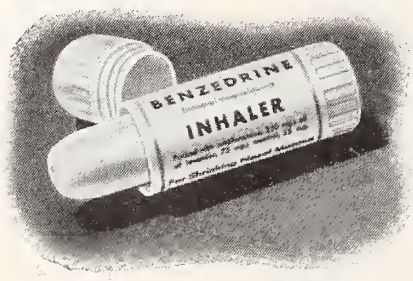
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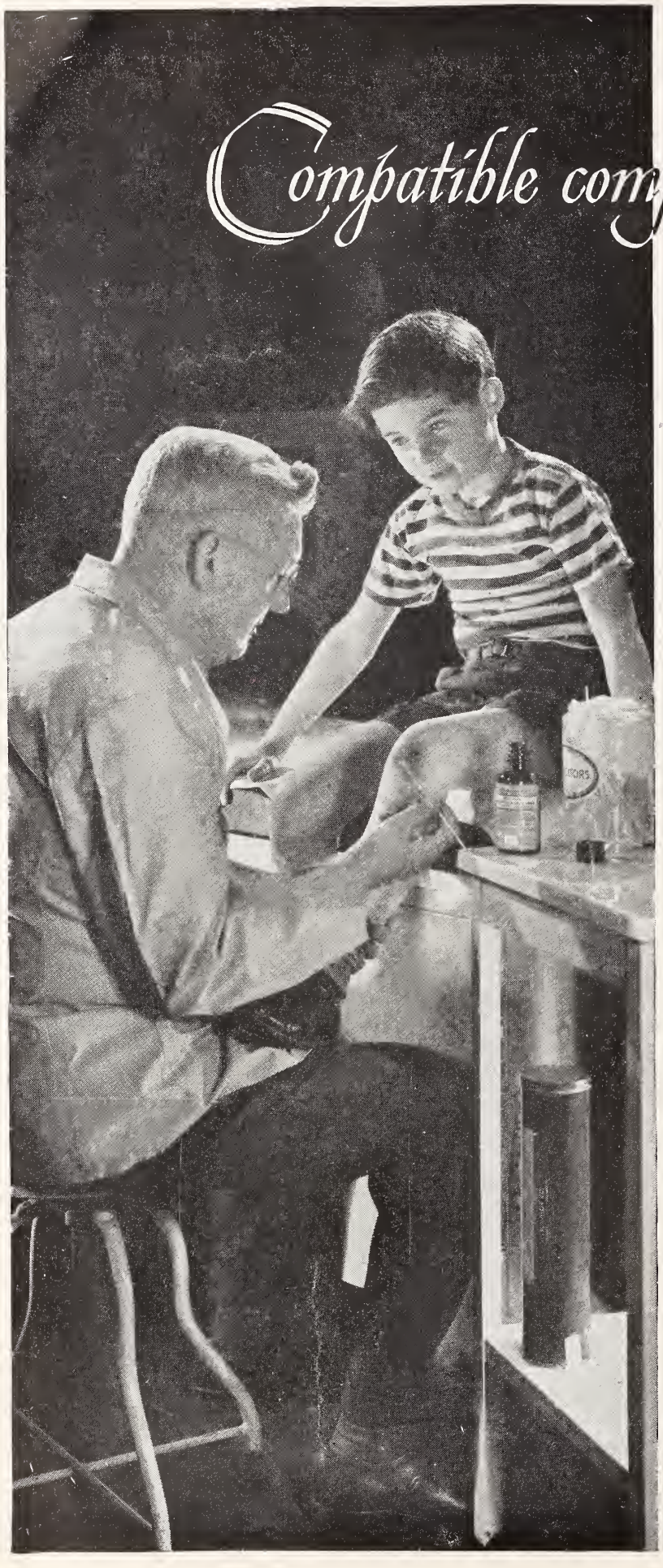
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# PROGRESS IN CANCER RESEARCH

JOHN J. MORTON, M.D., *Rochester, N. Y.*

The Author. *Surgeon-in-Chief, Strong Memorial and Rochester Municipal Hospitals; Professor of Surgery, University of Rochester School of Medicine*

DEFINITE progress has been made toward solution of the problems of cancer in spite of the interruption due to the world conflict. There had been a great stimulation of interest in this field with many investigations under way previous to the onset of the war and the results of these researches have been published so that cancer still occupies a large place in medical literature.

The main advances will be discussed under the following headings: new animal experimental material, tissue changes in carcinogenesis, hormonal studies, tissue culture studies, enzymes, effects of light, heterotransplantation, viruses and studies on human cancer. Only the highlights can be covered in the limited time at my disposal.

To my mind the most significant researches in the last five years are: the production of malignancy in vitro; the production of carcinoma in animals from their own intrinsic chemical factors; the hormonal control of some cancers; the heterotransplantation work of Greene; the modification of viruses by passage in young and alien hosts; additional discoveries on the milk factor: and the studies on the effects of light.

## NEW ANIMAL EXPERIMENTAL MATERIAL

Comprehensive tests of carcinogenic chemicals on animals have been carried out[59,101] and methods of analysis of the effects have been elucidated.[15,102] In the frog delayed fertilization leads to benign epidermal overgrowths; transplantation of adult frog carcinomas to tails of tadpoles is accompanied by regression of the tumor at metamorphosis; the same is true in tadpoles whose metamorphosis has been prevented by thyroidectomy or hypophysectomy; the tadpoles which had lost the transplanted carcinoma in metamorphosis, had tumors in the kidney on post mortem examination which raises the question of a virus origin.[13]

In mice brain tumors of all kind have been brought about by implantation of methylcholanthrene pellets;[124] fibrosarcomas induced by 4 azo compounds;[71] and by methylcholanthrene and other agents;[43] also fibrosarcomas and hemangioendotheliomas in mice and rats by many carcinogens;[43] breast carcinomas and lymphomatosis has been accelerated by methylcholanthrene in mouse strains normally having these malignancies;[38] lymphomatosis by methylcholanthrene also under similar conditions;[71] intestinal adenocarcinomas and intraabdominal hemangioendotheliomas by feeding methylcholanthrene;[119] sarcomas of the spleen by methylcholanthrene pellets.[101] Spontaneously arising hepatomas in mice provided opportunity to study many effects.[17] There was a decrease in spontaneous tumors in dba mice kept in a warm environment compared to a cooler one. The tumors were more slowly growing, taking twice as long to kill;[46] on the other hand, Wallace[117] showed that subcutaneously induced methylcholanthrene tumors arose and grew faster in a hot room than in a cold one, probably a vascular effect.

Pulmonary adenomas which occur naturally in A strain mice were accelerated by a single injection of urethane remote from their site of origin.[83] Lung

*From The Department of Surgery, The University of Rochester School of Medicine and Dentistry, Rochester, New York*
*Presented at the Twentieth Clinical Congress of the Connecticut State Medical Society, New Haven, September 29, 1944*

tumors which arose from methylcholanthrene did so because of local concentration in the lungs.[102] Six types of inhaled dust caused increased incidence of lung tumors;[21] soot from chimneys caused lung tumors;[102] tars from city air dusts caused sarcomas at the site of injection;[72] injection of dibenzanthracene into the animotic fluid was followed by increase in lung tumors in mice.[71] Adenocarcinomas of the pyloric end of the stomach were brought out by direct injection of chemical carcinogens into the region.[105] Strong et al[106] succeeded in getting a variety of gastric lesions including adenocarcinoma by subcutaneous injection of methylcholanthrene in NHO mice. Collins et al[25] found squamous cell cancers of the forestomach in mice of five strains which had been treated with benzyprene. Numerous extracts from overfried and overbaked meats were tested for carcinogenicity and gave negative results. Sesame oil heated to 350° C. induced sarcomas on subcutaneous injection in mice.[104]

In rats gastric cancer arose from patches of hemorrhagic ulceration in the animals fed with 1 per cent suspension of tobacco tar.[94] Brunschwig and Rasmussen[14] found that ulcero-papillomas and papillomas benign in type arose when rats were fed unbalanced diets. They warned against controlling the dietary factor. Morris and Lippincott[78] confirmed these results. No significant lesions were obtained by feeding overheated cholesterol.[67] A deficiency of cystine, riboflavine, pyridoxine or choline was followed by hyperplasia and ulceration of the forestomach epithelium of rats.[100] By feeding crude ergot Nelson[82] succeeded in getting neurofibromas on the ears of rats. These tumors regressed on withholding the drug but reappeared on feeding it. Sarcomas appeared about bakelite discs.[113] Mesenteric sarcomas followed the intraperitoneal injection of heated lard.[85] In mice, rats and guinea pigs salivary gland carcinomas and mixed tumors were induced by various carcinogenic chemicals.[104] Sarcomas followed the subcutaneous injection of methylcholanthrene in guinea pigs.[102] Leiomyofibromas were present in the peritoneal cavity when estradiol pellets were imbedded in guinea pigs.[122] Lipshutz[73] has carried on a series of investigations on fibroid tumors in the uterus and abdominal cavity of the guinea pig. These tumors were induced by estrogens of ten kinds, not influenced by hypophysectomy, but prevented by progesterone, desoxycorticosterone and testosterone. Roffo[94] has described carcinomas of the rabbit's ear induced by painting with tar from heated and oxidized cholesterol; and also from tobacco tar. Flory[42] in a very careful experiment could not produce carcinoma of the rabbit ear by tobacco tar. He did find carcinomatoid growths. Syverton and Berry[109] had carcinoma, sarcoma or both arising in rabbits from subcutaneous injection of methylcholanthrene in tricapylin. In a few dogs fed B-naphthylamine for one to five years Bonser[12] observed papillomatosis of the bladder with infiltration and invasion. Steiner and Brunschwig[104] reported on the spontaneous origin of carcinoma of the tongue in three old monkeys. There was no question of hot foods, rough teeth, ill fitting dental plates, tobacco or syphilis in the origin of these cancers.

### TISSUES CHANGES IN CARCINOGENESIS

Mider and Morton[77] called attention to a very unusual discovery that a single skin application of methylcholanthrene to C57 brown mice was followed by cancer. This work has been confirmed by Law[71] using another chemical carcinogen, and by Cramer and Stowell[29] for Swiss mice. The latter observers noted that a considerable total dose of a potent carcinogen applied to a large area of skin were the necessary conditions. The effects of a single external application of a potent carcinogen is much more persistent than hitherto suspected. It may be necessary to revise our conception that carcinogenesis invariably depends upon prolonged repeated trauma. In some susceptible animals at least, one single injury seems to set in motion the progressive steps to carcinoma. Confirmation of this view point has come also from experiments with a single application of x-rays. Malignancy developed in a strain of mice which previously had not manifested it spontaneously.[34] Sarcoma has been induced in inflamed tissue of rabbits by single doses of x-rays varying from 100 r to 2000 r. Burrows & Clarkson,[18] Mackenzie and Rous[75] furthermore reported that after an initial tarring of the skin of rabbits not sufficient to elicit tumor appearance, if wounds were inflicted on the tarred surface tumors arose in the healing tissues. This is of practical importance as it raises the issue of trauma localizing a growth in an area which may have contained latent neoplastic cells. Evidence of augmentation or cocarcinogenic effects has been reported by several authors. Berenblum[18] found marked increase in carcinogensis in mice, by use of croton oil, croton resin and chemical carcinogens, increase also noted by light cauterization and chemicals;[70] papilloma virus action greatly enhanced in domestic rabbits by preliminary

eatment with tar, turpentine or methylcholanrene;[45] and Rous and Kidd[96] showed the prompt ppearance of carcinoma when papilloma virus was jecetd intravenously into domestic rabbits whose in had been previously tarred. On the other hand cottontail rabbits, Syverton and Berry[109] could id no evidence of such acceleration from papilloma carcinoma when methylcholanthrene was used.

Local changes in the epidermis after application of carcinogen such as methylcholanthrene are; swellg of the epithelial cells and nuclei, multiplication, st by direct, later by indirect division;[90] a stimulan to cell division within 48 hours of a single plication—mitotic counts;[93] a marked increase in itosis for a period, a lag and then a rapid increase ain;[27] enlarged chromosomes and diplochromomes;[9] degeneration and disappearance of sebaceous and cells, epilation and flaking off of keratin;[103] crease of about 50 per cent of calcium and iron in e epidermis;[22] epithelial sodium, potassium and corbic acid not being affected;[22] total epidermal id material reduced 40 per cent in five days.[120] lottram and Weigert[79] noted that benzpyrene was ansformed locally into a blue fluorescing derivave confined mostly to the proliferating cells of the alphigian layer. It could be found in the milk and some other organs also. By fluorescence studies oniach confirmed that benzpyrene painted on the in was no longer extractable after 48 hours. A ue fluorescing derivative appeared in a few hours the site of painting and not elsewhere. It was ncentrated in the epithelial cells of the hair bulbs, creased to a maximum in five days and persisted r 2 to 3 weeks. The tumors formed in the malighian layer continuous with the hair bulbs. Simpn and Cramer pictured the blue violet fluorescence f methylcholanthrene, the bulk of it being in the eratin and sebaceous glands. It was excreted rough the sebum apparently. Reich and Dunning, id Taylor have demonstrated an antagonism beween tumor tissue and hemoglobin, the values for ie latter being low. In the lymphoid tissue, there is decrease in the lymphoid cells, an increase in the eticulum, dilatation of the lymph sinuses and increase in iron deposits.

### ISSUE CULTURES

Malignancy has been produced in vitro. Fibrolasts from the subcutaneous and adipose tissue of a 3 H mouse were grown in culture media to which ethylcholanthrene was added. The action of the arcinogen on the cells was progressive and gradual. Some of the control cultures showed the same changes presumably from slight contamination with the carcinogen. The changed fibroblasts were readily transplantable to the mouse strain $C_3$ H from which they arose. They frequently metastasized and usually caused the death of the host mouse. The cells were of connective tissue type, showed invasive capacity, much variability in cell pattern, some abnormal mitoses, and metastasized widely.[37] These cultures were found to possess a metabolism highly characteristic of malignant tumors generally. The tests included anaerobic and aerobic glycoysis, respiratory quotient, oxygen consumption, oxygen reserve, increase in $O_2$ consumption on addition of succinate or paraphynylenedianine (Pasteur effect), Meyerhoff quotient, biotin and miotin contents.[16]

Various human neoplasms have been successfully grown in roller tubes. They formed acini when benign but never when they were malignant growths. Squamous cell carcinomas in vitro produced structures resembling epithelial pearls.[26] Cells from pleural and peritoneal effusions grew vigorously indicating that they retained their vitality. Thus support was given to the view that carcinomatosis of serous membranes could occur by implantation.[26] Sano and Smith[98] found a critical level of 22°-24° C. of particular significance in respect to nuclear division. If cells were kept at this point for the proper time it was lethal. Tumors were tested under temperatures ranging from 0° to 37° C. As far as x-ray dosage is concerned it has been found to be the same for the total suppression of cellular outgrowths in normal rat fibroblasts and cells of chemically induced rat sarcomas in tissue cultures. It took a dosage of 200,000 "r."[55] Studies of Hodgkin's disease in tissue culture seem to rule out bacteria as a pathogenic agent. In several hundred cultures no specific bacterial contamination was observed. None has been demonstrated by using standard bacteriological stains, including the Giemsa and carbolfuchsin methods.[23]

### TISSUE ENZYMES

Enzyme systems have been studied extensively in comparable normal and neoplastic tissues. The spontaneous and the chemically induced hepatomas in rats and mice have made possible comparisons between their enzyme systems and those in normal livers, regenerating livers, and in the livers of animals bearing transplanted tumors. It would appear from these studies that when a normal tissue becomes neoplastic certain enzyme systems vanish or nearly

vanish; whereas other systems either remain the same or else increase in activity. This points to the necessity of thorough studies on several enzyme system before drawing conclusions. Those tissue components such as arginase, catalase, riboflavin, which are more concentrated in the liver than in other body tissues, are considerably diminished when the liver becomes neoplastic. The urea synthesizing mechanism is apparently missing in rat hepatomas. The iron containing components and the copper content of hepatomas are lower than for normal liver. The biotin values were much lower for hepatomas than for normal livers. Amylase actively in rat hepatomas differs very little from that in the normal, although the hepatomas are nearly devoid of glycogen. The enzyme histidase, which splits ammonia from histidine, is almost non-existent in hepatomas. Transaminase, concerned with the transfer of amino groups from amino acids to Keto acids, reaches a low level in hepatomas. Thymonucleodepolymerase, amylase, and certain of the peptidases are practically not affected by the neoplastic change. Acid phosphatase is significantly increased in hepatomas with one exception. Phosphatides and fatty acids in rat hepatomas are lower than in normal liver but both free and esterified cholesterol are distinctly greater. The content of nonprotein nitrogen, of amino nitrogen and of creatin and creatinine is practically the same in hepatomas and in normal livers. Water in hepatomas is distinctly higher than in normal livers. Sodium and chloride ion concentrations are also higher. The proportion of potassium in the tumor is phenomenal. These reports on one type of tumor indicate how complicated the problem is.

Studies on enzyme systems in lymph nodes, mammary gland, muscle, stomach, intestine, prostate, and bone have been carried out and compared with enzyme systems in tumors of the same tissues. In lymph nodes which have become neoplastic, thymonucleodepolymerase activity drops to a very low value. This is difficult to explain as the enzyme exists almost wholly in the nucleus. Pepsin and renin apparently vanish when gastric mucosa becomes neoplastic. Alkaline phosphatase which exhibits its greatest activity in the small intestine of all normal body tissues, nearly disappears in intestinal adenocarcinoma. The serum of patients with metastatic carcinoma from the prostate contains large amounts of acid phosphatase. Increased alkaline phosphatase activity is characteristic of growing bone, hyperplastic bone and osteoblastic types of osteogenic sarcoma.

No simple generalizations covering enzymatic e havior in tumors can be given at the present ti Some enzyme systems may decrease in activ others may increase and still others may not cha In general, the range of enzymatic activity is m greater among normal tissues than among tumor is as if tumors approached a common metabolic le All observations indicate that the systemic eff elicited by the tumor generally parallel in deg the growth of the tumor. Complete removal of tumor results in restoration of the distant enzy systems to normal.[52]

Many observations have been made on patie with gastro-intestinal malignancies. Vitamin A below normal range in the plasma of these patie After tumor removal it rises toward normal. Hepa dysfunction is relatively common in these peop The livers show fatty infiltration and decrea glycogen. There is impaired ability to fabric prothrombin and albumin; to esterify cholester to metabolize fat; to properly distribute Vitamin to excrete bilirubin; to convert bilirubin to urob inogen; and to synthesize or conjugate glucuronat These livers differ from the cirrhotic liver by reta ing their ability to esterify phenols. If glycine is a ministered intravenously in patients with th disorders the urinary excretion of creatine a creatinine fails to increase, another evidence hepatic dysfunction.[1]

In gastric carcinoma concentration of the ser proteins is below 6.6 gms. in a large proportion patients. The deficiency is due to serum albun alone in 73 per cent.[6] After total gastrectomy the is a conspicuous steatorrhea. This can be reduced beef supplements in the diet and by the use of pa creatic enzymes.[92]

Riboflavin in cancerous tissues is of low conte of the same order as in brain, spleen, lung and mus tissues but much below liver, heart and kidne Cancer tissues have a deficient aerobic oxidati system.[88] There is a relative decrease in nicotir acid content in the cancerous state and cancer relatively poor in biotin.[110,88]

### HORMONAL STUDIES

Intensive studies have been made on the hormor in relation to the cancer problem. The hormones the pituitary so far as we now know do not cause control any form of cancer. The same may be sa of the thyroid. Progesterone has never been imp cated in the production of cancer in men or a mals.[114] A tremendous amount of research has be

ne on the other ovarian hormone, estradiol, and its ar chemical relatives.[2] Gardner[47] has written a endid review on this difficult subject. The effects deficiency or excess of hormones have been proached by the removal or transplantation of gans; and by the injection of potent extracts or of rified chemical estrogens. The interrelationship th other ductless glands and the unexpected re-tions in other tissues have been carefully scrutin-d. Mammary, uterine, hypophyseal, testicular, mphoid and osteogenic tumors have appeared in imals of some species or strains when they are posed to estrogens for prolonged periods. Other tors, hereditary, etc., modify the carcinogenic sponse. The estrogens directly or indirectly affect e tissues giving origin to the tumors but the tumors pear only in susceptible animals.

The difficulties in interpretation of these experi-nts is well illustrated by mammary cancer in ce. Here, it is evident that at least three influences ust be taken into account. One is the genetic nstitution,—susceptibility; two, the hormonal mulation of the breast,—without mammary tissue ere could be no mammary cancer; and three, there some factor which is transmitted in the mother's lk. This was proved by foster nursing mice from w to high breast cancer strains and vice versa. The ogeny grew up with the tumor rate characteristic their foster mother so that their genetic constitu-n was overthrown.[10] In continued investigations the milk factor, it was found that whole blood rried the material influencing mammary cancer cidence.[123]

Subcutaneous injection of extracts of mouse lac-ing mammary gland, splenic tissue or milk in-ced mammary tumors.[4] Feeding ground up mam-ary tumors gave a high incidence of mammary mors.[15] The active influence may be transferred inoculation of spleen, thymus or lactating mam-ary gland from cancerous stock animals. A milking achine was devised for mice and the milk influence us brought to direct investigation. It is active in ophylized tissue, desiccated tissue, glycerinated sue and after passage through a Seitz filter.[10] cording to DeOme[31] the active agent is primarily the non-fat fraction from ultracentrifuged mate-l. Bryan[15] thought most of the principle was in e chalky pellet. Visscher[116] found that homogen-ed tissue contained 71 per cent of the agent. After tracentrifugation the second sediment contained per cent,—the fat fraction only 14 per cent. He believes that it is probably a colloid of high molecular weight,—may be a virus. Shimkin[102] concludes that there is no apparent dilution of the agent and that it is either self producing or stimulates a similar amount in each mouse for transmission to the progeny. Fekete and Little[40] transferred ova directly to the uterus from one strain of mice to another. The mice born of these transferred ova were nursed by the mothers which gave birth to them. In addition to the foster nursing these mice were also subjected to the intrauterine environment of their foster mothers. Significant differences were observed indicating that the intrauterine influence is also important.

One of the most striking developments in the hormonal studies came following castration of mice at birth or shortly after. Hyperplasia of the adrenal glands, was followed by mammary gland development in male mice.[123] In other mice of the "ce" strain, gonadectomized at two days of age, carcinoma of the adrenal cortex occurred reaching 100 per cent at one year of age. It was accompanied by mascuinization of both males and females.[123] Tumors of the adrenal glands arose in mice of the N H strain ovariectomized at any early age.[47] These researches indicate that cancer can arise in animals from substances which they produce intrinsically. No carcinogens of any kind were added in these experiments.

In the clinical field hormones have been used to control malignant growths especially those of the prostate. The results have been quite remarkable. Huggins[64] used castration for palliation in advanced cancers of the prostate. The immediate results were dramatic except for a small group which did not respond. Relief of pain came within 24 to 48 hours after orchiectomy. No further opiates were necessary. There was improvement in energy and well being. They ate better and gained weight. Some, who were bed ridden, recovered the use of their paralyzed ilmbs. The destructive areas in the bones filled in with new bone. Enlarged lymph nodes, presumably with cancer in them, receded and could no longer be felt. Metastatic nodules in the lung fields got smaller and even disappeared from chest films.[3] The nodules in the prostate smoothed down so that the gland became normal to palpation. The residual urine lessened in amount and infection tended to clear. The acid phosphatase in the blood serum receded to normal and the alkaline phosphatase rose slowly. A certain number of patients got

relapses and recurrences. Some few patients, however, have remained well a number of years.

It is well to remember that cancer of the prostate is a slowly progressing lesion usually. It will take a little more time to estimate the ultimate end results. The androgens activate adult prostatic epithelium. They cause the cuboidal cells to become columnar in shape and to produce an increased amount of acid phosphatase. This substance can be stained in the prostatic cells. It gets into the blood serum when prostatic cancer metastasizes. When the acid phosphatase is high it means that the growth has extended beyond the prostate. Androgens given to patients with cancer of the prostate cause increase in the symptoms and in the size of the cancer. Orchiectomy acts by removing the androgen effect. The successful palliation may be correlated with the well differentiated adult carcinomas; whereas those that fail to respond represent the embryonal undifferentiated type, though there is not complete agreement here. Diethylstilbestrol may be used also in the treatment of advanced prostatic cancer. It acts by neutralizing the androgen effect. It requires repeated administration.

The use use these hormones has demonstrated that physiological differentiation between two types of prostatic cancer is possible; that the majority of prostatic cancers are composed of mature epithelial cells, an important basic discovery. Apparently dedifferentiation toward a more primitive pattern is not always an essential step to malignancy. It is possible that removal of the inciting agent (androgens) may lead to dormant malignant cells. It is conceivable that the affected cells may be changed back to normal ones, though postmortem studies so far indicate quiescence only. A new chemical blood serum test has been found which is useful in diagnosis, prognosis and treatment of prostatic cancer.[54] It is helpful in differential diagnosis between prostatic cancer of bone and Paget's disease. It may be of assistance in determining whether the primary tumor is prostatic in widespread metastases. The tissue enzyme acid phosphatase is markedly reduced in the prostate following castration. At post mortem such a gland contained only eight units per gram of fresh tissue, as against 500 to 2000 for the normal adult gland.[3] Dean[30] has demonstrated that from the point of view of hormones excreted in the urine, the treatments by castration and diethylstilbestrol differ completely. Castration seems to cut estrogenic excretion in half, tends to raise 17 ketosteroid excretion and to release the pituitary from testicular inhibitic so that it pours out excessive quantities of gonad tropins. Stilbestrol raises the estrogenic excretic rate, and decreases the other two.

Murphy and Sturm[80] have demonstrated an i creased susceptibility to inoculated rat leukaemia adrenalectomized animals. Injections of adrenal co tical hormones or pituitary adrenotropic hormon led to a definite increase in survival of rats inoculate with transplantable lymphatic leukaemia. The mea ing of these observations must await further e perimentation.

The significance of the hormones in human canc needs more research before we can really say muc In animals hormones are contributing factors carcinogenesis without doubt. Comparable quantiti of estradiol in the human breast cancer would ca for enormous doses.[51] There is no proof that th hormones are the direct cause of carcinoma of th breast.[81]

LIGHT EFFECTS

Clinicians generally believe that there is a rel tionship between skin cancer and sunlight. Attemp to bolster this assumption have been made by caref studies on ultraviolet radiation.[97,11] Tumors in ra and mice can be produced in this way. Rabbits an guinea pigs are refractory to this agent. It has bee determined that the wave lengths which produc tumors in rats and mice lie between 2900-3200 The wave lengths shorter than 3200 a may b effective also in human cancer. These wave lengt are completely absorbed in 0.5 mm. or less of huma skin. The mouse skin is thinner than the huma which accounts for the difference in the pathologic types of tumor.[68] In mice and rats 94 per cent a sarcomas and only 6 per cent squamous cell ca cinomas. In the human, the tumors are epithelia The sites of neoplastic growth are about the ear nose, eyelids, eyes and paws of rats and mice. Th production of the tumors depends on the quantit of radiant energy applied rather than on the inter sity of radiation.[11] The first reaction is the thicker ing of the epidermis which protects against trans missability of the radiant energy. This makes difficult to say that hyperplasia is an essential facto for tumor formation.[11] In fact, in hairless rats wher the skin is naturally thicker, hyperkeratosis result from ultra violet radiation and no malignancies ar produced.[63] Only cells which receive the prope amount of damage may become malignant. Durin

the first exposure period developmental changes take place. In the rest period following, the process advances or regresses. It becomes a struggle between growth and regression processes. When the balance is tipped toward growth, tumors appear. Their proliferation is always under some degree of control by the tissues. The tumor cells do not assume their own essential proliferation rate. They do not escape and grow autonomously.[11] Once carcinogenesis is initiated it proceeds without further radiation.[97] The determination of the wave lengths by which ultra violet tumors are produced in animals is a very important advance. It proves that erythema effects are not involved because these occur with wave lengths below the carcinogenic range. Photodynamic and pigment reactions occur above the wave lengths concerned. No conclusions can be drawn as to the action.[11] Figge[41] believes that porphyrins produced in the harderian glands of rats and mice might explain some of these phenomena. In rats and mice the porphyrins have a red fluorescence. This is failing in rabbits and guinea pigs. The porphyrins may sensitize the cells to the action of the light. The sites at which the tumors appear correspond to the areas where porphyrins from the harderian glands tend to accumulate.

### HETEROTRANSPLANTATION

The brilliant researches of Greene[50] have opened a new and promising approach to problems of cancer. The method of transplantation of malignant tumors to the anterior chambers of rabbit's eyes has led to the successful transplantation of these tumors into other locations. It has become possible to transplant malignant tumors from one species to another via the anterior chamber route. Thus, rabbit cancers have been transplanted to the eyes of guinea pigs and swine,[50] human carcinomas and sarcomas to the eyes of rabbits and guinea pigs,[50] chemically induced brain tumors in mice and human brain tumors into the eyes of mice and guinea pigs,[44] frog carcinomas to eyes of other species of frogs and toads.[74] It was discovered further that although adult normal tissues could be transplanted to the anterior chambers of animals of the same species (homo-transplantation) that they could not be transplanted in this way to a foreign host (heterotransplantations). Normal embryonic tissue could be transferred to the eyes of the same or to those of a foreign species. Whole embryos of mouse, rabbit and human origin have been successfully transferred to the anterior chambers of the eyes of rabbits and guinea pigs. Teratomas resulted which could be carried serially. Parts of organs transplanted in this way underwent differentiation and resembled adult structures.[50] After human fibrosarcoma had been carried through fourteen generations in the eyes of guinea pigs it could then be transplanted successfully into guinea pigs testicles.[50] Guinea pigs were found to be superior to rabbits as the host for human tissue transplants.[50]

Adult normal tissues could not be transplanted to an alien species. Embryonic liver and organs of internal secretion could not be transferred to the eyes of foreign hosts. To date all benign tumors and precancerous lesions have failed on transplantation even in the same species.

In the anterior chamber growth may be quite variable. Sometimes it became apparent in a few days. At other times the graft remained dormant for as long as 500 days but still retained vitality as noted on reinoculation in the native host (guinea pig to rabbit).[24] In frog's eyes when the host was kept at 4° C. in hibernation, there was no growth for 80 days but after that growth was progressive under normal conditions.[74] Growth cannot be predicted on every grafting so that a series of animals should be prepared. Tissues which may be infected should not be used in intraocular grafting.

The transfer of human cancer to the lower animals thus could be of great assistance in morphological classification. It could be used to bring out the underlying cellular picture. Cellular differentiation and organization have been more sharply defined in this way. Foreign body tissue reacting cells were eliminated by this transfer as they did not possess autonomy. After preliminary growth in the anterior chamber transfer could be made readily to other regions. Here also reversions and changes in cellular pattern may be demonstrated. Thus, what appeared to be spindle cells in a rabbit tumor became typical squamous epithelial cells in the aqueous humor. On transfer to the testicle, the spindle cell type reappeared. Embroynic human squamous epithelium appeared to be spindle cells in the guinea pig's eye. And the reverse was noted when a supposed human fibrosarcoma assumed epithelial characters on transplant to the guinea pig's eye. These spindle celled appearing epitheliomas have been noted in previously irradiated epithelium and they have offered great difficulty in diagnosis to the pathologist. Greene has thus demonstrated that the degree of differentiation may be influenced to a considerable extent by local

environmental conditions. It has not been explained why transplantation is successful in the anterior chamber. Greene has demonstrated that the aqueous humor participates in general body reactions. Appel claimed compliment fixation antibodies did not gain access to the aqueous fluid. In animals immunized against a tumor, there appeared to be some agent in aqueous capable of destroying a graft of the tumor tissue. No foreign body reactions were demonstrated about the failing grafts.

From these studies Greene concluded that the acquisition of malignancy was a series of progressive stages involving hyperplasia, anaplasia, local invasiveness and complete autonomy. Complete autonomy was an outcome of continued development and was not a common attribute of all neoplastic cells. There was no relationship between anaplasia, the degree of differentiation and autonomy. Hetero-transplantation was possible only when the growth under study had the ability to invade foreign tissue or to metastasize in the primary host. The only tissues which could be transferred to a foreign species were normal embryonic tissues and tumor tissues which had attained autonomy. Autonomy thus transcended species barriers and one change in the cancerous development of a cell is loss of species identity.

### VIRUSES

The most striking development in the virus field has been in the transformation of the Rous sarcoma virus by passage through new born and adult avians of the same or of different species. In new born ducks following intravenous injection with the virus two types of tumors developed. One type came early within thirty days. It showed characteristics of sarcoma growing in chickens and was transmissable to chickens but not to ducks. The tumors which were delayed in appearance for several months after injection were different in type from the chicken sarcomas. These tumors were transmissable to ducks but not to chickens. The virus had undergone variation in this passage. Many other variations in the passage were worked out. Several duck variants of the Rous virus were thus originated. Similar experiments were successful in turkeys and guinea fowls.[36]

Taylor[110] implanted the yolk sacs of five day chick embryos with saline suspensions of fresh tissue from a spontaneous mammary carcinoma of a dba mouse. After 12 days of incubation the yolks of these eggs (which had relatively large growing tumors) was diluted and passed through an N sized Berkefeld filter. Dba mice injected with this filtrate grew tumors which were transplantable, rapidly growing, histologically malignant and which metastasized to the liver and peritoneum. The evidence favored a virus substance, which was caught and preserved by the surrounding yolk. This work should be confirmed.

### STUDIES OF CARCINOMA IN THE HUMAN SUBJECT

It has been conclusively shown that substances which have carcinogenic properties can be extracted from various tissues of humans who have died of cancer (Shabad). Additional evidence has been obtained by extracts from the livers,[32,61,104,28] of cancerous and to a less extent from non-cancerous subjects. Extracts from gall bladder bile[104] and from the lungs[69] were also successful as well as extracts from human mammary cancer.[76] Sarcomas were usually induced at the site of injection in mice.

The excretion of steroid substances in the urines of cancerous and now cancerous subjects has been investigated. This is an exceedingly difficult technical project and will require more time before conclusions can be drawn. Dobriner et al[33] have constructed patterns to show the differences in the excretion of a number of these substances. The normal urines showed a constant ratio whereas patients with cancer and adrenal hyperplasia gave both quantitative and qualitative differences. Cancer patients excrete smaller quantities of ketosteroids than normal patients do.[33] This has been confirmed by Pearlman.[86] In patients with breast cancer the total urinary estrogens and androgens and 17 ketosteroids were not significantly different from the normal.[111,81,95] In hirsutism and virilizing syndromes the 17 ketosteroids are elevated above the normal.[56]

In studies on skin cancer, it was shown that the cancerous tissue retained no evidence of purposeful proliferation. When a defect was made in the skin directly through an epithelioma healing occurred only from the normal skin edges. The cancer did not extend along the incised margin. Lateral spread continued at the margins of the growth that were undisturbed by operative trauma.[14] Sutton[108] found that each epithelioma behaved like a colony of cells, probably from a mutation, and there was no evidence of conversion of normal cells to cancer cells by contact. Uhlman[115] was able to differentiate between a recurrent cancer ulceration and a radiation ulcer by the healing response following the application of a radon ointment.

The diagnosis of cancer of the cervix can be made by identification of the cells in vaginal

smears[84] and there is a higher percentage of more extensive involvement, less favorable types and a earlier incidence of cancer of the cervix in syphilitics.[58]

Fluorescence can be observed in tumors which originate from tissues normally containing vitamin A, such as ovarian tumors. The fluorescence microscopic picture suggests an adrenal origin for hypernephromas.[89]

Cancer of the testicle has been studied in relation to non-descent, inguinal or abdominal testes. Undescended testicles are more susceptible to malignancy than scrotal ones; and abdominal testes more than those in the inguinal canal.[20,7,57] When one testicle has had carcinoma there is quite a likelihood for the second one to later become neoplastic (15 per cent inguinal, 30 per cent abdominal).[57]

Orchiectomy has given striking results in some cancers of the male breast.[39] Castration may give temporary improvement in about one-third of the patients with recurrent or inoperable cancer.[81] Roentgen rays also have been recommended for this purpose.[87]

Adrenal deficiency may follow operation on patients with Cushing's syndrome.[19] This may be prevented by administration of cortical hormone and electrolytes.[49]

In gastric cancer the question of preceding atrophic gastritis has been argued pro and con. Shapiro[99] claimed 80 per cent showed microscopic evidence of it; and Hebbel[60] could find no evidence that cancer arose with unusual frequency in diffuse gastritis. It is difficult to controvert the careful studies of Guiss and Stewart[53] on this point. They could not support the thesis that chronic atrophic gastritis is a precancerous lesion.

Tracer studies with radioactive salts have demonstrated that there is selective absorption of certain salts by certain tissues. Selective radiation can be administered in this way. The lymph nodes absorb 3½ times as much radioactive phosphorus as the general body tissues[65] but although there was clinical improvement in the lymphosarcoma, biopsies showed no changes attributable to radiation.[65] Radioactive phosphorus has been useful in chronic lymphatic leukaemia, chronic myelogenous leukaemia and lylmphosarcoma but not in acute or subacute types.[65] In the latter it does not change the disease to the chronic form. The concentration was mostly in those tissues which usually show heavy infiltration with leukaemic cells. Bile concentration was sometimes fairly high.[118]

Radioactive iodine was taken up by thyroid tissue and its metastases, the latter taking a higher proportion. On second injection the metastases took up none, indicating impaired function.[66]

Radioactive strontium was taken up by growing bone and osteogenic tumor.[112] Woodward[121] found that there was an inhibitory factor in many osteogenic sarcomas which prevented the utilization of alkaline phosphatase in the storage of phosphorus.

Progress is being made in prevention clinics. Hope for earlier diagnosis lies in earlier recognition of some forms of cancer. The survey clinics for gastric lesions, breast, and pelvic cancers point the way for future progress.

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# THE THERAPY OF BREAST CARCINOMA

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## SURGERY

HALSTEAD in 1893 devised the modern surgical procedure for radical mastectomy. Although modifications have been introduced through the years, primarily in the configuration of the skin incision, the procedure remains essentially as developed by its originator. The operation accomplishes the purpose for which it was designed namely, complete removal of the neoplasm and the accessible contiguous lymphatic drainage areas. Although it is realized that surgery is not the complete solution to the therapeutic problem of breast cancer it is the best method available to date for combatting this disease. As advances are made in other fields of medicine and science new agents are developed for attacking neoplasms such as the hormonal and chemotherapeutic products.

Since the best chance for a five year survival is offered by radical surgery this procedure should be used in every case where it is possible. Those instances in which the radical procedure is not feasible but where there is no contraindication to surgery one of two other procedures may be employed viz: a modified radical or a simple mastectomy.

### CONTRAINDICATIONS FOR SURGERY

About 11 per cent of the cases seen at the Memorial Hospital are unsuitable for any type of surgery. The presence of any of the following manifestations places them in that category:

1. Extensive edema of the breast integument.
2. Metastatic nodules in the skin of the breast or chest wall.
3. Edema of the arm.
4. Fixation of the tumor mass to the chest wall.
5. Supraclavicular or cervical metastases.
6. Inflammatory type of carcinoma.
7. Distant metastases.

Edema of the skin and the presence of cutaneous nodules are due to interference with the lymphatic drainage by widespread cancer. The blockage may produce diffuse edema of the skin and areola and it may cause retrograde spread of the cancer cells in the subdermal lymphatics. At various points the cancer cells are forced from the underlying blocked lymphatics into the upper layers of the skin to form cancer nodules. Edema of the arm is produced by extensive involvement of the axillary lymphatics and may be a sign of encroachment on the axillary vein by the disease. The fixation of the tumor mass to the chest wall may be the result of direct spread of the disease along the lymphatics accompanying the perforating branches of the internal mammary vessels or it may result from the production of fibrous tissue. The latter is a characteristic of some breast carcinomas and accounts for the phenomena of adherence and dimpling of the skin over these tumors and of nipple retraction.

Supraclavicular and cervical node involvement may be due to retrograde metastasis. The disease is so extensive that there is interference with normal lymph drainage and the cancer cells are carried by the reversed lymphatic flow to the supraclavicular and cervical nodes.

All of the foregoing types of cases are technically operable, but it is known from experience that surgery in these instances does not offer the patient any greater life expectation than non surgical procedures and in many instances is definitely detrimental.

### INDICATIONS FOR MODIFIED RADICAL AND SIMPLE MASTECTOMY

Simple mastectomy is the removal of the breast leaving the pectoralis muscles intact. The modified

*From The Breast Service of Dr. Frank E. Adair, Memorial Hospital, New York. Presented at the Twentieth Clinical Congress, New Haven, September 29, 1944*

adical as devised by Adair involves the development of flaps as in the radical procedure, the pectoral muscles, however, are not removed. By strong medial traction on the pectoral muscles it is possible to expose a considerable part of the lower and medial axillary space as far as the lateral border of the pectoralis minor and perform a rather extensive axillary dissection.

In selected cases one of these procedures is performed if the lesion is operable but it is thought that the patient's condition is unsuitable for radical surgery. In this category are elderly, debilitated individuals, over 75 years of age with marked myocardial damage, hypertension or other organic condition. In younger individuals, diabetes, hypertension, myocardial damage, unless the heart is badly decompensated, does not militate against radical surgery. Our experience is in agreement with that of Senturia[27] who in an analysis of a group of cases found that hypertension is no contraindication to radical mastectomy.

Cancer is a lethal disease and the patient should be given the chance for cure offered by the radical procedure despite the presence of hypertension or other organic conditions with the few exceptions stated above. In these instances the modified radical or simple mastectomy may be advisable.

## Irradiation Therapy

X-radiation as a therapeutic agent in breast carcinoma may be employed as follows:

1. Preoperatively.
2. Postoperatively.
3. For inoperable disease.
4. For metastatic disease.
5. For inflammatory carcinoma.

### Preoperative irradiation

For a period of six years preoperative irradiation was employed at the Memorial Hospital in every case with operable carcinoma of the breast. Its use has been discontinued because it was found that it did not increase the percentage of five year survivals. Its employment necessitated a delay before operative procedures could be instituted, caused bleeding at operation and prolonged wound healing. In some instances it may make an inoperable case technically operable but since the fixation of the tumor is due to spreading disease the patient, on the basis of five year survival, is not benefited by the procedure.

### Postoperative irradiation

Adair[2] has shown that the five year salvage is increased by the use of postoperative x-ray therapy in cases with axillary disease. The procedure at the Memorial Hospital is to administer postoperative x-ray therapy to all cases with lymph node involvement. Also in young or middle aged women without node involvement but with an anaplastic type of carcinoma, for example grade 4, postoperative irradiation is employed. The patient is treated through 3 portals; anterior, posterior and direct axillary employing a voltage of 250 K.V. and a skin dose of 1800 to 2000 r measured in air to each of the 3 portals. Therapy is started about 6 weeks after the operation at which time wound healing has progressed to a point where the x-rays will not act adversely. Adair at the Memorial Hospital has obtained 77 per cent five year survivals with surgery alone if no nodes are involved and 41 per cent five year survivals with surgery and postoperative irradiation if the nodes are involved. Shields Warren[32] has produced some evidence recently from which it would appear that the chances for 5 year survival depend not only on the presence or absence of node involvement but on the number of nodes involved. He believes that the fewer nodes involved the better is the prognosis. Treatment by x-ray alone was tried by Adair in a series of 182 unselected operable cases of carcinoma in which the diagnosis had been established by biopsy. Only 44 or 24.2 per cent survived the 5 year period. If this figure is compared with those given above for the results from surgery alone and the combination of surgery and irradiation (an average survival rate of 59 per cent) it is readily seen that radiation therapy alone cannot take the place of adequate surgery.

### Inoperable disease

If the disease is inoperable radiation therapy is employed as a palliative procedure. The same factors are used as for postoperative irradiation. The breast is treated through a medial and lateral port each of which receives about 2500 r measured in air. Lee,[19] in an analysis of 124 cases of primary inoperable carcinoma of the breast treated by x-radiation at the Memorial Hospital found that there was relief from pain, healing of superficial carcinomatous ulcers, improvement in general condition and prolongation of life. Elderly and debilitated individuals should not be subjected to heavy or prolonged irradiation because they do not tolerate it well and the lesions do not respond satisfactorily. Persistent treatment to

supraclavicular or axillary disease is inadvisable because the disease may not be eradicated and the only result will be an intractable neuritis of the brachial plexus.

METASTATIC DISEASE

Metastatic skeletal lesions respond well to high voltage irradiation and the patient is symptomatically improved for longer or shorter periods of time. Metastatic lymph nodes also frequently yield to this mode of treatment. Radiation therapy to pulmonary lesions is unsatisfactory. In some instances the lesions diminish in size or even disappear but the progress of the disease is not altered. Symptomatically there is little improvement even if the metastatic lesions decrease in number or size because of the resultant radiation fibrosis. This produces the same symptoms, viz: cough and dyspnea that are caused by the metastases. Pleural effusion secondary to pressure from mediastinal metastases on the inferior vena cava and pulmonary vessels may be diminished by shrinking these foci with irradiation and thus relieving the stasis. The effusion recurs when the mediastinal nodes again enlarge. Superficial metastatic nodules in the skin of the chest wall respond well to low voltage therapy. If the nodule is solitary it is best treated by surgical excision followed by irradiation through a cone to encompass the localized area.

INFLAMMATORY CARCINOMA

In this variety of carcinoma the breast is red and the surface temperature elevated. On palpation there is a well developed thickening of the involved portion of the breast. The line of demarcation of the process is well defined, both to the visual and tactile senses. The edge is definitely thickened and raised. The physical manifestations are produced by engorgement of the subcutaneous lymph spaces with cancer cells. This type of neoplasm does not respond well to surgery. On the contrary surgical procedures are detrimental—the cancer cells are disseminated with a rapidly fatal progress of the disease. These cases are best treated by radiation therapy. Although the outlook for cure is poor this method offers better palliation and greater expectation of life than does surgery.

## Hormone Therapy

Numerous investigators stimulated by the work of Lacassagne[16] and of Loeb[20] have shown that the administration of the estrogenic hormones produces mammary carcinoma in mice. The employment of androgens to counteract this carcinogenic effect of the estrogens was a logical consequence. That this result could be achieved in animals was early established by several investigators (Lacassagne, Raynaud,[24] Murlin[22]). The clinical use of the hormones in the treatment of cancer is of relatively recent date. Encouraged by the gratifying results from the employment of the estrogens in carcinoma of the prostate some investigators have tried the androgens in carcinoma of the female breast. Loesser[21] reported in the Lancet 6 cases treated with testosterone propionate. All had been subjected to radical mastectomy some time previously. Three of the patients had had recurrences which had disappeared after treatment by irradiation, and were clinically free from disease when the medication was initiated. These remained free from the disease for 5 years (date of publication) following the hormone therapy. Since there was no evidence of disease when the hormone therapy was instituted, the recurrent disease having been eradicated by irradiation, the proof that the hormone was responsible for the situation is not convincing. The remaining 3 cases had evidence of metastatic disease when hormone therapy was initiated. These patient died within a short time after this treatment was started. There was no evidence that the hormone had influenced the disease in any respect. A recent report by Fels[9] described the use of testosterone in 4 cases of female breast carcinoma with osseous metastases. Three patients failed to show any improvement whereas the fourth was improved symptomatically, which was evidenced by a subsidence of pain and cessation of vomiting. As this case was under treatment only 4 months at the time of the report it is too soon to pass judgment. A study was made by Farrow[8] at the Memorial Hospital to determine the effect of testosterone on women with bone metastases from breast carcinoma. This therapeutic procedure failed to produce symptomatic improvement or alter the course of the disease and the patients died within a few months. There was an interesting change in the blood chemistry produced by the administration of the testosterone namely, a sharp rise in the serum calcium which persisted for a week or ten days after the cessation of the therapy. This was associated with headache, nausea and vomiting which subsided when the serum calcium level returned to normal.

Roentgen studies in these patients revealed a rapid increase in the size of the pre-existing skeletal

metastases as well as the appearance of new foci. From these studies it would appear that androgen therapy has a distinctly deleterious effect on cases of carcinoma of the female breast with osseous metastases. I saw recently a patient with osseous metastases from a breast carcinoma whose chief complaint was vomiting. On inquiry it was found that she was receiving injections of testosterone propionate. The nausea and vomiting subsided when this therapy was discontinued. From the available evidence it does not appear that the androgens exert a beneficial effect on the course of carcinoma with metastases but on the contrary, may be distinctly detrimental.

Recently some English investigators[35] have begun a study of the influence of estrogens on advanced carcinoma of the breast. Whereas the results to date are inconclusive there is some evidence that the hormone may have a beneficial effect in some instances on women of the older age group, i.e. over 60 years of age. The improvement manifests itself in a decrease in size and occasional disappearance of the breast lesion or skin nodules. There is no improvement in bone metastases. However, the widespread use of the estrogens in gynecology, in breast conditions such as chronic cystic mastitis and for breast tumors some of which ultimately prove to be carcinoma, merits some notice. Although much is known about the carcinogenic effect of estrogens on the mammary gland of the mouse little is known of their effect on the human mamma. Auchincloss[4] recently reported a case of breast cancer possibly induced by estrogenic substances and Allaben[5] described a case of adenocarcinoma of the breast coincidental with strenuous endocrine therapy. Parsons[23] also reported a case of breast carcinoma in which he believed estrogens may have played a major etiological rôle. Foote and Stewart[10] of the Department of Pathology at the Memorial Hospital have just completed a study of 10 cases in which the patients had received estrogen therapy ranging over periods of several months to 2 years and then had a local excision of a benign breast lesion or a radical mastectomy for carcinoma. These authors were not able to detect structural patterns in these breasts which could be considered as specifically characteristic. There was one case, however, in which extraordinary changes were seen which possibly depended upon administration of estrogenic substances.

Cramer[6] believes that the therapeutic use of the estrogenic hormones for gynecological conditions which does not extend beyond a period of a few months does not involve a risk of subsequent cancer. However, he is of the opinion that a substitution therapy extending over several years, analagous to the use of insulin or thyroid hormones does involve a risk especially in susceptible individuals, that is, in women with a family hsitory of cancer. Heredity as a factor in human breast cancer has been demonstrated by the statistical studies of Waaler[31] and of Wassink.[33] The former studied an extensive series of cases in Norway and the latter an equally large group in Holland. Both concluded that there is a definite hereditary factor in human carcinoma, strikingly shown in carcinoma of the breast.

I have seen two cases of carcinoma of the breast in which the lump was treated by administration of estrogens. Both patients gave similar histories. The lump had been small and present for several months without noticeable increase in size. During a few months of estrogen therapy the rapid increase in the size of the mass disturbed the patient to the extent of impelling her to change doctors. A radical mastectomy was performed in each case.

### Castration

That the ovaries might exert an influence on mammary cancer was suggested by Sir Astley Cooper[7] in 1836. Castration as a therapeutic procedure was initiated by Schinzinger[26] in 1889. Since that time the procedure has been employed by many surgeons with beneficial results in many instances. In 1904 Foveau de Courmelles[11] in France used the x-ray as a method of producing castration. This technique has become increasingly popular through the years because it obviates a surgical procedure which carries a certain mortality and morbidity. For the past 18 years castration has been carried out at the Memorial Hospital in selected cases and recently these have been analyzed by Adair.[3]

During that period 307 women have been castrated by x-ray and 33 by surgery. Only patients with metastatic or inoperable disease were selected and only those who lived more than 2 years or in whom the course of the disease was materially altered were considered improved. Of the group castrated by irradiation 15 per cent showed improvement whereas of those castrated surgically 13 per cent obtained benefit. The favorable manifestations have been symptomatic improvement such as relief from pain, stimulation of the appetite with a gain in weight and a feeling of well being. In some instances there was radiographic evidence of bone regenera-

tion and a definite increase in life expectancy. Since there is no appreciable difference in the percentage of improved cases by the two methods the Breast Service at the Memorial Hospital employs the x-ray technique because the mortality, morbidity and financial cost are lower than with surgery.

Stimulated by the favorable results following castration for carcinoma of the prostate reported by Huggins,[14] a series of seven males with metastatic or inoperable carcinoma of the breast have been castrated surgically at the Memorial Hospital in the past 3 years. In general the results have been encouraging. Symptomatically some of these patients have been benefited and the disease process has been definitely slowed. In two instances there was regression of the primary lesion and in some cases the procedure has produced bone regeneration in metastatic areas and regression of lung metastases. We now employ surgical castration in all males with inoperable or metastatic breast carcinoma.

### Pregnancy

From clinical experience it is known that the prognosis in patients developing carcinoma of the breast in the course of pregnancy is distinctly poor. As a general rule pregnancy is detrimental to a woman harboring any unarrested malignant tumor. Lee[18] advocated a radical mastectomy and a therapeutic abortion at one sitting. Smith,[28] on the other hand believes that the radical mastectomy should be performed as soon as the diagnosis is established but that the prognosis is better if the pregnancy is not interrupted. This question is still an open one.

The policy of the Breast Service at the Memorial Hospital at present is to abort the patient in the early months. A radical mastectomy is then performed. If the pregnancy is more advanced it is allowed to go to completion and then the radical mastectomy is done. Pregnancy is interdicted for a period of 5 years in women who have had a carcinoma of the breast even though they are apparently free from disease. If pregnancy intervenes within that period the woman is aborted.

### Chemotherapy

Recently some new compounds have come from the laboratories with enthusiastic reports respecting their cancerocidal properties. Only two of these, heptylaldehyde and H 11 will be considered.

#### HEPTYLALDEHYDE

The encouraging reports of Strong[29] and of Garai[12] on the liquefaction and disappearance of spontaneous mammary gland carcinoma in mice after repeated subcutaneous injections of heptylaldehyde sodium bisulfite prompted us[1] to try its effect on human mammary carcinoma. For this purpose we selected a group of 14 women ranging in age from 31 to 61 years who had carcinoma of the breast varying in duration from 1 to 15 years. In four instances the lesion was inoperable whereas in the remainder the disease was recurrent after surgery. All patients had skeletal metastases proved roentgenographically. During the period of administration of the heptylaldehyde no x-ray or other therapy was employed. Eleven patients received the compound by the oral route over a period of three weeks and were followed for several months thereafter. Some received 6 gms. daily in divided doses and the remainder 12 gms. per diem. The latter dose administered to a 50 kilogram (110 lb.) woman corresponds to the 6 mg. per day dose which causes liquefaction and disappearance of mammary tumors in mice.

In none of our cases was there any significant change in the course of the disease. Neither was any change observable in the size or consistency of the breast tumor in those cases where one was present. Roentgenological studies failed to reveal any regression of the osseous metastatic lesions. On the contrary some cases exhibited further spread of the metastatic disease and increase in size of existing lesions. Symptomatically there was no decrease in the weakness or in the pain referable to the skeletal metastases. The patients complained of pyrosis and nausea if no food was taken after the heptylaldehyde. Three patients were hospitalized and kept on a continuous intravenous drip of 5 gms. of heptylaldehyde per kilogram body weight for an interval of 3 weeks. As with the patients treated orally there was no demonstrable influence on the course of the disease, the local lesions, metastases or the symptoms. These cases continued to progress, one dying within a month after the cessation of the treatment. During the course of the treatment the patients exhibited occasional toxic effects evidenced by diarrhea, headache and slight convulsive movements. Strong described similar toxic manifestations in mice evidenced by unusual irritability, unprovoked squealing and jumping. Since the effect of the compound on the tumor depends on the sulfite component, studies of the sulfite concentration of the blood were carried out on the patients receiving the compound by the intravenous route. Only traces of bisulfite could be found in the blood so that it is

likely that this radicle is quickly oxidized, probably before the compound reaches the tumor in effective concentration.

To summarize, although heptylaldehyde causes liquefaction and disappearance of spontaneous tumors in mice it had no demonstrable effect on the breast tumor, metastases, or course of the disease in 14 women treated with dosages comparable to those which produced the effect in mice.

H 11

In the past few years some investigators (Rhodenberg,[25] Thompson[30]) have described growth inhibiting properties of urinary extracts. One of these products, isolated by Thompson and designated by him H 11 has been extolled by its discoverer as having an inhibitory effect on the growth of mouse neoplasms. This has not been substantiated by other investigators, (Gye,[13] Woodhouse[34]).

H 11 has been used to some extent in England for the treatment of human cancer and some has recently been received in this country. An extensive clinical trial was carried out by Kidd[15] in England. He administered the compound to 51 patients with advanced carcinoma three of which were of breast origin. All of the cases were inoperable when H 11 treatment was instituted. Most of the cases had had previous surgery or irradiation. Protocols of the 3 breast cases are as follows:

CASE 1

A 60 year old woman with scirrhous carcinoma who refused operation or radiation therapy. She received 540 injections over a period of 8 months. Examination at the end of that period revealed that the growth had increased from 1 to 1½ inches in diameter. Subsequently lost to follow-up.

CASE 2

A 46 year old woman, previous therapy not stated, who received a daily injection for a total of 31. She died 3 months after cessation of therapy.

CASE 3

35 years old. Adenocarcinoma of the breast with metastases to the lungs and retina. Previous therapy not reported. She received 496 injections over a period of 8 months. Examination at that time—"pain in back and shoulders. Totally blind. Can get about but becoming weaker." Lost to follow-up.

Summarizing his study of the 51 cases the author states, "There was some evidence that in a few instances the rate of growth was slowed up or inhibited but in no case confirmed by section as yet has any growth disappeared as the result of H 11 therapy only."

## Summary and Conclusions

Radical mastectomy in properly selected cases produces the highest percentage of five year survivals of any therapeutic procedure for breast cancer. There are definite contraindications to surgery, which if not respected make this procedure detrimental instead of beneficial. Preoperative irradiation does not increase the number of five year survivals. However, postoperative irradiation in patients with anaplastic carcinoma or with axillary node involvement is distinctly advantageous. X-ray therapy should not be relied upon to supplement incomplete surgery. Castration either by x-ray or surgery is of value in about 15 per cent of cases. In inoperable or metastatic carcinoma of the male breast surgical castration is the method of choice. The employment of androgens in the treatment of carcinoma of the female breast is of questionable value and may be detrimental. There is no histological evidence that estrogens influence human mammary cancer although there is some clinical evidence in this respect. Pregnancy associated with mammary cancer makes the prognosis unfavorable and should be terminated. Heptylaldehyde causes destruction of mammary carcinoma in mice but it is of no therapeutic value in humans. H 11 similarly has been disappointing as a therapeutic agent.

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# THE PERIODIC GYNECOLOGICAL EXAMINATION

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ALTHOUGH the value of the periodic gynecological examination has been appreciated for many years by gynecologists, it is only recently that there has developed a widespread interest in its potentiality for the safeguarding of health and the early detection of cancer in relatively large groups of individuals. A considerable impetus to this increased interest has derived from a Report on the Value of Periodic Pelvic Examination in the Control of Cancer made in June, 1944, by Catherine Macfarlane[1] and her associates in Philadelphia. This work is important not only because of the significance of the findings of pelvic and other pathology in a relatively large group of women, but also because it suggests a technic by which this type of diagnostic examination service may be developed for such groups. Similar studies by other observers have also appeared within recent months and a survey of the results presents many points of interest other than that relating to the discovery of cancer. A brief summary of some of these studies is important for our consideration if we are to evaluate the future of this type of periodic examination.

As in other fields of medicine, statistical studies on presumably healthy people are remarkable for their paucity. For the most part those relating to women are to be found chiefly in hospital records and, here, mostly in parous women. The studies that are here summarized are revealing and fundamentally important.

The Philadelphia study was begun in the spring of 1938 and the patients represented 1,319 volunteers between the ages of 30 and 80. Four hundred sixteen individuals came regularly twice each year for five years. The examination consisted essentially of a careful bimanual vaginal examination with careful inspection of the cervix. In January, 1942, the examination of the breasts was added. On May 15, 1944, a total of 9,111 pelvic examinations had been made and 18 cancers of 10 different organs had been discovered. On the first examination of 1,319 volunteers, early cancer of the cervix was found 3 times. The authors state that these were found in areas of papillary erosion and it "lends support to the theory that cancer tends to develop in these so-called areas of epithelial restlessness." From a general health standpoint, of important interest was the incidence of benign lesions of the pelvis; thus, cystic tumors of the ovary were seen 40 times, inflammatory lesions of the cervix 461 times, mucous polyps of of the cervix 118 times, myomatous tumors of the uterus 167 times, leucoplakia 3 times, papillomas 2 times.

Another interesting review of findings is found in the report of Carey and Gaskill[2] on the routine pelvic examination of 1,998 women. This group of white women, most of whom were under 40 years of age, were apprentice seamen in the Naval Reserve. The findings may be thus summarized: approximately one-third of the group had some type of gynecologic condition predominately of a minor nature. The incidence of major pathology as presented here errs on the side of conservatism since some 10 to 15 per cent had had previous pelvic examinations at the Procurement Offices, and some cases were undoubtedly eliminated because of major pelvic pathology. Despite this the figures on the incidence of fibromyomata uteri and ovarian cysts are higher, in these authors' opinions, than would be expected. The total incidence of the former were 27.5 per thousand and 9 ovarian cysts were found, 6 of which required operation. Of the 1,998 predominantly young women, 10 were candidates for major surgery, 2 had a history of metrorrhagia, 8 women required removal of cervical polyps, 27 had vaginitis, 244 had cervical erosions or cervicitis. Thus, 291 of 1,998, mostly young and presumably healthy women, required gynecologic treatment.

A report of further interest is that of F. D. Gibson,[3] of the United Aircraft Corporation at East

Hartford, on Gynecological Examinations in Industry. The study includes 407 married women whose history showed that they had been pregnant and/or had symptoms indicating pelvic pathology. These women accepted a pre-employment gynecological examination. One hundred forty-three, or 35.1 per cent showed no pelvic disorder "worthy of note." Of the remaining 264 women, 64.9 per cent showed 326 pelvic defects. On the basis of the findings, it was decided that a gynecological examination shall be a requisite for the employment of all women who have been pregnant and whose work will entail any heavy lifting, and of any woman applicant whose history suggests pelvic pathology. Gibson considers that pelvic examination of such women employees is as important as the examination of males for hernia.

In a discussion of the Philadelphia experience, Augusta Webster of Chicago cited the findings on the first 400 cases examined at a clinic started in May, 1943, at the Women's and Children's Hospital in that city. In this group were found 5 carcinomas of the breast, 2 carcinomas of the breast, axillary, 1 basal cell carcinoma of the scalp, 1 basal cell carcinoma of the face, 1 adenocarcinoma of the fundus and 2 advanced inoperable pelvic cancers. The following possible malignant growths were also discovered: 2 breast masses, 3 friable polyps, 5 skin lesions, 1 suggestive lesion of the tongue, 1 postmenopausal bleeding, 1 suggestive (ovarian?) mass, 1 case of suggestive gastric symptoms and 1 lymphatic leucemia.

As may be conjectured from this category, the scope of the Chicago enterprise was enlarged to include a general physical examination and routine laboratory procedures, such as urinalysis, blood count and the Wassermann test, the emphasis being placed upon general health as well as upon the detection of early cancer.

It is obvious that in the development of any program for periodic examination it should include a general history, a general physical examination and certain routine laboratory tests. The Chicago plan conforms to this and even goes further in its completeness, as may be judged from a personal communication from Dr. Webster. She writes:

"Before our clinic was opened we sent a plan to the Chicago Medical Society, and obtained the approval of the Chicago Medical Council. Our policy is to send the patient back to the medical situation from whence she came with some information about the nature, but not the extent, of our findings and we urge her to have her doctor request a report from us. We do not send the reports unless they are requested, however. More than 1,000 patients have passed through the clinic and, as would be expected, we have encountered more other ailments than tumors, either benign or malignant. All patients have Wassermanns, smears, hemoglobins, red counts, white counts, blood smears and urinalysis, as well as chest fluorscopics. We now have some third year women residents doing the initial history and examinations. These girls are paid at the rate of our local Board of Health Clinic people. All of their findings are summarized, and on the patient's second visit (all come to the clinic twice) an older doctor sees her and interprets the findings, and reinvestigates any major pathology. The consultant to whom the patient is assigned depends upon the pathology present. All of the consultants are giving their time gratis, and represent the specialties of dermatology, otolaryngology, radiology, surgery, internal medicine, gastro-enterology and gynecology. We have been fortunate in obtaining Board members in all these fields. Each patient is first seen by a medical social worker who takes a social history. The recommendations of the consultants are passed on to the social worker who dismisses the patient at the end of the second visit. The social workers have been invaluable to us. We do not treat any patients, and we do not admit anyone to the clinic who is at the time under treatment for cancer."

In considering the reports here presented and in particular Dr. Webster's communication it seems likely that for this type of periodic examination to be effective for a considerable number of individuals, it should in most instances be organized as a clinic or institutional procedure. For effective and consistent work a close proximity and cooperation of special consultants, assistants and laboratories seems invaluable. It may be assumed therefore that in any hospital where an obstetrical and gynecological ward service is maintained such a clinic could be readily set up as a follow up procedure for discharged patients. A definite trend is to be seen at present toward hospitals as diagnostic centers and the periodic gynecologic examination suggested as a follow up clinic for ward patients follows this direction.

It is evident from the experience summarized that this type of periodic examination for parous women and for all women over thirty is of signal value not

only for the early recognition of serious pelvic pathology but as a safeguard for general health. With regard to the former it is apparently the only means by which early and curative cancer in the breast and pelvic regions can be discovered in the vast majority of instances.

It is not the purpose of the present communication to consider in detail or to evaluate technical procedures. However, the following general outline may be useful as a follow up procedure on obstetrical and gynecological patients.

1. Patients to be interviewed before leaving the hospital and the importance of the periodic examination emphasized.

2. To be seen at six month's intervals.

3. At the time of examination.

a. The recording of a history to supplement the hospital record.

b. General physical examination to include careful breast examination and determination of blood pressure.

c. A vaginal and rectal examination including speculum examination of vagina and cervix, vaginal smears and specimen for biopsy when indicated.

d. Laboratory procedures as indicated—urinalysis at each visit.

As to the time necessary for such a routine periodic examination it is probable that not less than one half hour should be planned for each patient. Assistance in history taking and in other procedures might shorten this time after clinic organization is completed and operation experience gained.

IN SUMMARY

A plan is suggested for the follow up clinics of obstetrical and gynecological wards to extend their services to include a periodic gynecological examination on somewhat broad lines to include a general physical examination. Statistics are quoted to show the great value of such a program for the early recognition and cure of many varieties of pelvic pathology including cancer.

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# MEDICAL SERVICE PLANS

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THE Hospital Service Plan Commission of the American Hospital Association has prepared a compact and useful brochure which describes in brief a group of non profit medical service plans sponsored by local or state medical societies and operated in coordination with approved Blue Cross Hospital Plans.

Only the more essential data are given for each prepayment plan, and detailed administrative provisions are omitted. The information presented for the majority of the plans includes a statement on organization and operation, relationship with the Blue Cross Hospital Plan in the area, subscription rates, benefits, eligibility and payments to physicians.

These data do not readily lend themselves to compilation and graphical presentation because of the many variations in the combination of features and provisions offered by the plans. This applies particularly in the case of benefits, where the protection for the subscriber ranges from surgical service in the hospital only to complete medical and surgical service in hospital, office and home. In some instances, specific statements are made concerning payment for anesthesia, diagnostic x-rays and laboratory service, in others information on these points is not contained in the descriptions. With a few exceptions, however, the salient features of these plans for prepaid medical service can be determined. Those which appear to be of general interest and pertinence are the type of contract, i.e., whether service or cash indemnity; the coverage available to the subscriber and dependents; the subscription rates and income limits; and the relationship with the medical society and the hospital care plan.

In order to facilitate comparison of these features, a table has been prepared which lists the medical service plans alphabetically by the states in which

| ORGANIZATION DATE | TYPE OF CONTRACT: SERVICE | CASH INDEMNITY | SURG. | OBS. | COVERAGE: HOSP. MED. | OTHER MED. | ANES. | X-RAY | LAB. | OTHER |
|---|---|---|---|---|---|---|---|---|---|---|
| 1939 California, San Francisco: California Physician's Service | X | | X | X | | Subscr. only | No information | | | |
| 1942 Colorado, Denver: Colorado Medical Service | X | | X | X | – | – | all | $15.00 | $15.00 | – |
| Connecticut: Connecticut Medical Service | | X | X | X | – | – | Limited | Limited | not established | – |
| 1943 Delaware: Group Hospital Service | | X | X | X | – | – | $10.00 | $15.00 | – | – |
| Iowa | X | | X | X | X | – | No information | | | |
| 1942 Massachusetts: Massachusetts Medical Service | X | | X | X | – | – | all | $15.00 | – | – |
| 1940 Michigan: Michigan Medical Service | X | | X | X | – | – | all | $15.00 | – | – |
| 1943 Missouri, Kansas City: Surgical Care | X | | X | X | – | – | all | $15.00 | – | Radio-therapy |
| 1944 New Hampshire: New Hampshire Physician Service | | X | X | X | 25 calls subscriber 15 calls dependent | | $10.00 | $25.00 | $15.00 | – |
| 1942 New Jersey: Medical-Surgical Plan of New Jersey | X | | X | X | X | – | No information | | | |
| 1940 New York, Buffalo: Western New York Medical Plan | | X | X | X | 25 calls subscriber 15 calls dependent | | all | yes | yes | Radio-therapy |
| 1942 New York, N.Y.: United Medical Service | X | | X | X | | | No information | | | |
| 1939 New York, Utica: Medical and Surgical Care | | X | X | X | 52 calls subscriber 150 calls–family | | $10.00 | $5.00 | $7.00 | |
| 1941 North Carolina: Chapel Hill Hospital Saving Association of N. C. | | X | X | X | | | | | | |
| North Carolina, Durham: Medical Service Association | | X | $25.00 X | X | 8 days X | Limit $50.00 | – | – | – | Consultation $10.00 |
| Ohio | | X | X | X | X | | No information | | | |
| 1940 Pennsylvania: Medical Service Association of Pennsylvania | X | | X | X | – | – | – | – | – | – |
| 1944 West Virginia, Huntington: Huntington Hospital Service | | X | X | X | X | – | X | X | – | Radio-therapy |
| Canada: | | | | | | | | | | |
| British Columbia: Medical Services Association | X | | – | X | X | X | – | X | X | Consultation |
| Manitoba, Winnipeg: Manitoba Medical Service | X | | X | X | X | X | $70.00 | $15.00 | – | Consultation |
| Commercial Insurance Co. Plans: | | | | | | | | | | |
| Illinois, Winnebago Co.: Winnebago County Medical Society Plan | | X | $2.00 per call $250 maximum adult, $500 maximum for all children | | | | | | | |
| Ohio, Toledo: Electric Auto-Lite Group Hosp. and Surg. | | X | X | X | – | – | – | – | X | – |

they operate. Where definite data are available, an X has been used as a positive symbol, a short line (–) as a negative symbol. In addition to the plans described in the pamphlet of the Hospital Service Plan Commission, there have been here included the known facts on the prepayment plans which are about to begin operation or are under consideration in Connecticut, Iowa, and Ohio. There have been also added two plans, one of which is sponsored by a county medical society but is still in the organiza-

| RATES | | INCOME LIMIT | | MEDICAL SOCIETY SPONSORSHIP | BLUE CROSS COORDINATION | | | ORGANIZATION |
|---|---|---|---|---|---|---|---|---|
| SURGICAL | MEDICAL | SINGLE | FAMILY | | A | B | C | DATE |
| .60 - $2.25 | .75 addit. | | $3,000 | Yes | | | X | 1939 California, San Francisco: California Physician's Service Medical rider (2 visit d.) for subscr. only |
| .75 - $2.00 | — | $1,400 | $2,400 | Yes | | X | | 1942 Colorado, Denver: Colorado Medical Service |
| Not established | | None | | Yes | | X | | Connecticut: Connecticut Medical Service |
| .60 - $1.65 | — | None | | ? | X | | | 1943 Delaware: Group Hospital Service |
| No information | | | | Yes | No information | | | Iowa |
| .85 - $2.00 | — | $2,000 | $2,500 | Yes | | X | | 1942 Massachusetts: Massachusetts Medical Service |
| .60 - $2.25 | — | $2,000 | $2,500 | Yes | | | X | 1940 Michigan: Michigan Medical Service |
| .75 - $2.00 | — | $1,800 | $3,000 | Yes | | X | | 1943 Missouri, Kansas City: Surgical Care |
| .75 - $1.75 | | None | | Yes | | X | | 1944 New Hampshire: New Hampshire Physician Service |
| .75 - $2.00 | | None | | Yes | | X | | 1942 New Jersey: Medical-Surgical Plan of New Jersey |
| .60 - $1.70 | | None | | Yes | | X | | 1940 New York, Buffalo: Western New York Medical Plan |
| | | $1,800 | $2,500 | Yes | | X | | 1942 New York, N. Y.: United Medical Service |
| .75 - $1.90 | .65 - $1.70 | None | | Yes | | X | | 1939 New York, Utica: Medical and Surgical Care |
| Incl. hospital 1.20 - $2.50 | | None | | ? | X | | | 1941 North Carolina: Chapel Hill Hospital Saving Association of North Carolina Combined hospitalization and surgical benefits |
| Combined 1.43 - — | $2.82 - — | None | | Yes | | X | | North Carolina, Durham: Medical Service Association Combined Hospital, Medical-surgical benefits |
| | | | | Yes | | X | | Ohio |
| .68 - $1.75 | — | $1,500 | $3,000 | Yes | | | X | 1940 Pennsylvania: Medical Service Association of Pennsylvania |
| $1.00 - $2.00 | .50 - $1.00 | None | | Yes | X | | | 1944 West Virginia, Huntington: Huntington Hospital Service |
| | | | | | | | | Canada: |
| — | $1.15 - $2.35 | Not stated | | Not stated | | | X | British Columbia: Medical Service Association |
| .60 - $1.75 | Combined $1.50 - $3.50 | $1,800 | $2,400 | Yes | | X | | Manitoba, Winnipeg: Manitoba Medical Service Surgical or surgical-medical contract available |
| | | | | | | | | Commercial Insurance Co. Plans: |
| $3.00 / month / family | | Not stated | | Yes | | | | Illinois, Winnebago Co.: Winnebago County Medical Society Plan |
| Ward $1.09 Semi-private: $1.24 - $3.64 | $3.14 | None | | ? | | X | | Ohio, Toledo: Electric Auto-Lite Group Hosp. and Surg. Combined hospital-surgical contract |

tion stage, operated by commercial insurance carriers. It is obvious that many of the provisions of the plans not yet in operation have not been determined and cannot therefore be indicated in the table.

It will be noted from the column headed "Type of Contract" that all of the prepayment plans are classified as *service* or *indemnity* plans. Under the service prepayment plan, the physician underwrites the medical and/or surgical services to the patient and is paid in full by the insuror. The payments,

which are based on a unit system or a predetermined fee schedule, are subject to proration as the income of the plan flucuates and the participating physician accepts this condition. In an indemnity agreement, the plan contracts to pay to the physician or patient a stipulated sum which is a credit towards the physician's bill. The physician is free to charge an amount over and above this allowance. Of the plans here tabulated, eleven are service and eleven are indemnity type.

In some features the prepayment plans show sufficient uniformity to obviate the necessity of including these provisions in the table. In providing obstetrical coverage, for example, a waiting period of ten to twelve months is generally stipulated. Waiting periods are frequently required also for certain surgical procedures, notably tonsillectomies and herniotomies. Exclusions under the various contracts are closely similar, if not identical, comprising in many cases preexisting conditions, narcotic or alcohol addiction, venereal disease, tuberculosis, mental illnesses and those covered by Workmen's Compensation Acts.

Relatively few of the plans offer medical coverage. It should be pointed out that, where such benefits are included, the subscriber is generally allowed a maximum number of home, office or hospital calls annually, and his dependents are allowed a lesser number. In at least one instance (California Physicians Service) the medical rider is available to the employed subscriber only.

Limitations of space made it necessary to show only a range of the subscription rates for the plans. It is the usual practice to establish a rate for the employed individual male as the lowest, and successively higher rates for the employed individual female, for two persons and for the family, i.e., husband, wife and dependent children from 90 days to eighteen years of age. Benefits for dependents are frequently less extensive than for the employed subscriber.

Income limits are defined in the majority of service plans for the purpose of enabling the physician to charge an additional amount beyond the allowed fee for services to patients with incomes above the stated maximum.

Coordination with Blue Cross Hospital Plans, shown in the right hand column, is of three basic types, coded here as A, B and C.

A—identical corporate structure and administrative personnel.

B—separate corporate structure with identical administrative personnel.

C—separate corporate structure and separate administrative personnel.

# A STUDY OF DISTRIBUTION OF PHYSICIANS IN CONNECTICUT IN WARTIME

## Prepared by the Procurement and Assignment Service for Connecticut

CREIGHTON BARKER, M.D., *Consultant, New Haven*

DATA RELATIVE to the total number of physicians in the state and their distribution and many other factors related to medical care have been under constant accumulation and study by the Procurement and Assignment Service for Connecticut for nearly three years. Some of the statistics gathered and studies made have been required as a part of the national analysis of physician distribution, other points have been studied because of local or personal interest. The circumstances have changed so rapidly and the situation has been in such a fluid state that the presentation of a definitive report was not practical until lately. Now, however, movements have been stabilized at least temporarily and it is possible to set forth certain interesting observations.

### POPULATION

Between 1940, the date of the decennial census, and 1943, the date of the last general census estimate, the population of the counties showed changes. These were not actually as great as were popularly estimated because such estimates did not take into consideration the withdrawal of many thousands of residents for military service. The housing shortage was considered by some to be an evidence of vast population increase and it did reflect population movement. But, it should be taken into consideration that each newcomer attracted here by a job in industry required housing and if he brought his family with him, it too had to be housed. On the other hand withdrawals for military service usually took

in individual or two out of the household while the household unit remained as it was. The population changes as reported from government sources for the counties of Connecticut from 1940 to 1943 are as follows:

Table I

| COUNTY | POPULATION 1940 | 1943 |
|---|---|---|
| Fairfield | 418,384 | 434,265 |
| Hartford | 450,189 | 474,286 |
| Litchfield | 87,041 | 87,662 |
| Middlesex | 55,999 | 58,635 |
| New Haven | 484,316 | 477,763 |
| New London | 125,224 | 129,384 |
| Tolland | 31,866 | 32,327 |
| Windham | 56,223 | 54,080 |

DISTRIBUTION OF PHYSICIANS

The State of Connecticut was well supplied with physicians before 1940 and the physician population ratio here ranked well within the higher ratios in the country. The state has furnished proportionately its share of medical officers to serve with the Army and Navy, and with recruiting for these Services largely completed, statements of the balance between the physicians and population can be made. At the beginning of the war the Procurement and Assignment Service in consultation with the United States Public Health Service and the Armed Forces arrived at the conclusion that generally speaking, a distribution of one physician to each fifteen hundred of the population was a reasonable working basis. Five Connecticut counties are now above this ratio, that is to say that there is one physician for less than each fifteen hundred of the population. One county meets the established ratio almost exactly and two rural counties are below it. It may be noted that in one of these counties the one to fifteen hundred ratio did not exist prior to the war. The distribution of physicians in proportion to population in the eight counties of Connecticut follows:

Table II

| COUNTY | PHYSICIAN-POPULATION RATIO |
|---|---|
| Hartford | 1 - 1102 |
| Fairfield | 1 - 1130 |
| New Haven | 1 - 1169 |
| Middlesex | 1 - 1274 |
| Litchfield | 1 - 1348 |
| New London | 1 - 1522 |
| Windham | 1 - 2001 |
| Tolland | 1 - 2155 |
| *State as a Whole* | 1 - 1196 |

In making the computation shown in Table II, only physicians engaged in actual medical practice are considered. No physicians in full time employment of any kind are included in the computation, except the few who are engaged in full time industrial practice. In this case it was considered that such physicians contribute enough to individual medical care in the community to warrant their inclusion. Physicians employed in public health, institutional or teaching activities, and hospital residents and interns are not included.

DISTRIBUTION OF ALL PHYSICIANS BY AGE AND ACTIVITY

Table III-A—Fairfield County

| AGE GROUP | ACTIVE PRACTICE | HEALTH DEPT. TEACHING & OTHERS | RETIRED |
|---|---|---|---|
| Under 35 | 49 | 2 | 0 |
| 36 - 45 | 108 | 8 | 0 |
| 46 - 55 | 95 | 10 | 2 |
| 56 - 65 | 76 | 7 | 3 |
| Over 65 | 56 | 6 | 24 |
| Total | 384 | 33 | 29 |

Table III-B—Hartford County

| | | | |
|---|---|---|---|
| Under 35 | 27 | 11 | 2 |
| 36 - 45 | 115 | 30 | 3 |
| 46 - 55 | 141 | 19 | 4 |
| 56 - 65 | 90 | 14 | 2 |
| Over 65 | 57 | 8 | 14 |
| Total | 430 | 82 | 25 |

Table III-C—Litchfield County

| | | | |
|---|---|---|---|
| Under 35 | 3 | 0 | 1 |
| 36 - 45 | 20 | 0 | 0 |
| 46 - 55 | 16 | 0 | 0 |
| 56 - 65 | 9 | 0 | 0 |
| Over 65 | 17 | 1 | 3 |
| Total | 65 | 1 | 4 |

Table III-D—Middlesex County

| | | | |
|---|---|---|---|
| Under 35 | 3 | 3 | 0 |
| 36 - 45 | 16 | 5 | 0 |
| 46 - 55 | 12 | 6 | 0 |
| 56 - 65 | 7 | 4 | 0 |
| Over 65 | 8 | 1 | 5 |
| Total | 46 | 19 | 5 |

Table III-E—New Haven County

| | | | |
|---|---|---|---|
| Under 35 | 24 | 38 | 4 |
| 36 - 45 | 94 | 28 | 2 |
| 46 - 55 | 140 | 18 | 3 |
| 56 - 65 | 89 | 15 | 4 |
| Over 65 | 62 | 5 | 27 |
| Total | 409 | 104 | 40 |

Table III-F—New London County

| AGE GROUP | ACTIVE PRACTICE | HEALTH DEPT. TEACHING & OTHERS | RETIRED |
|---|---|---|---|
| Under 35 | 4 | 9 | 0 |
| 36-45 | 27 | 7 | 1 |
| 46-55 | 20 | 4 | 1 |
| 56-65 | 23 | 2 | 4 |
| Over 65 | 11 | 1 | 16 |
| Total | 85 | 23 | 22 |

Table III-G—Tolland County

| | | | |
|---|---|---|---|
| Under 35 | 2 | 0 | 0 |
| 36-45 | 3 | 1 | 0 |
| 46-55 | 3 | 2 | 0 |
| 56-65 | 4 | 1 | 0 |
| Over 65 | 3 | 0 | 2 |
| Total | 15 | 4 | 2 |

Table III-H—Windham County

| | | | |
|---|---|---|---|
| Under 35 | 2 | 0 | 0 |
| 36-45 | 10 | 0 | 0 |
| 46-55 | 3 | 0 | 0 |
| 56-65 | 4 | 0 | 0 |
| Over 65 | 8 | 0 | 5 |
| Total | 27 | 0 | 5 |

Table III-I

PERCENTAGE OF PHYSICIANS OVER 65 YEARS OF AGE IN ACTIVE PRACTICE

| COUNTY | PERCENTAGE |
|---|---|
| New London | 12.9% |
| Hartford | 13.3% |
| Fairfield | 14.6% |
| New Haven | 15.2% |
| Middlesex | 17.4% |
| Tolland | 20.0% |
| Litchfield | 26.1% |
| Windham | 29.6% |

HOSPITALIZATION

The distribution of general hospital beds in proportion to the population is shown in Table IV.

Table IV

| COUNTY | NO. GENERAL HOSPITAL BEDS | NO. HOSPITAL BEDS PER 1,000 POPULATION | AVERAGE BED OCCUPANCY |
|---|---|---|---|
| Hartford | 2168 | 4.5 | 77.6% |
| New Haven | 2029 | 4.5 | 77.9% |
| Litchfield | 393 | 4.4 | 62.7% |
| New London | 458 | 3.5 | 64.9% |
| Fairfield | 1497 | 3.4 | 73.7% |
| Windham | 170 | 3.1 | 75.2% |
| Middlesex | 152 | 2.5 | 82.8% |
| Tolland | 85 | 2.0 | 69.0% |

ECONOMIC FACTORS

The distribution of physicians is influenced by many factors such as the economic status of the population and social and natural environments. Retail sales is one index of prosperity. The retail sales per capita are given below:

Table V

| COUNTY | SALES PER CAPITA |
|---|---|
| Windham | $1,010.00 |
| Litchfield | 967.00 |
| Hartford | 828.00 |
| Fairfield | 795.00 |
| New Haven | 732.00 |
| New London | 694.00 |
| Middlesex | 591.00 |
| Tolland | 429.00 |

The average per capita retail sales for the state is $781.

The monthly rental of dwelling units not occupied by the owner is an index that reflects property value. Average monthly rentals for dwelling units of all grades are as follows:

Table VI

| COUNTY | AVERAGE MONTHLY RENTAL |
|---|---|
| Fairfield | $43.95 |
| Hartford | 37.07 |
| New Haven | 33.89 |
| Middlesex | 32.43 |
| Litchfield | 31.32 |
| New London | 31.20 |
| Tolland | 23.49 |
| Windham | 20.59 |

GENERAL CONSIDERATIONS

Questions will undoubtedly arise seeking an explanation of some points set forth in this report, but no conjectures are offered or statements made that do not have statistical basis. One fact is, however, self evident. It is that the counties are arbitrary, political units whose origin is obscure and they bear no relationship to economic or social factors, routes of travel or avenues of trade. Except in certain small governmental functions, the counties cannot be considered as isolated units and this is particularly true of medical care and hospitalization. Physicians serve back and forth across county lines and in some instances a large part of hospitalization may be carried by another county.

An interesting query may arise on the discrepancy in per capita retail sales between Tolland and Windham counties for these counties are much the same in physical and industrial characteristics. Some rather plausible conjectures might be found in explanation, but they are not susceptible to proof within the limits of this study.

A comparison of the present wartime distribution of physicians with pre-war physician-population ratio is not offered. Before the war it was customary to compare the gross number of physicians with the population and this inevitably resulted in a high ratio of physician to population because all retired physicians and physicians in full time employment were included. It is only since the Procurement and Assignment Service has classified physicians accurately that a true estimate of circumstances can be made and a comparison of present day statistics with pre-war figures should not be made.

Wartime conditions in Connecticut may be compared with other localities. Data submitted by the Procurement and Assignment Service show that at the end of 1943, 533 counties had more than 3,000 people, 141 counties more than 5,000, and 20 counties had more than 10,000 people per active physician in private practice. In addition 81 counties, 30 of which had a population of more than 3,000, had no practicing physician.

SOURCES OF ERROR

The data used herein are from accepted and reliable public and private sources. The population figures are probably too high as of January 1, 1945 since they were computed at the time of the highest industrial activity in the state and since then it is believed an out-migration of workers has taken place and the number of men discharged from military service and returned to the state has been less than the number withdrawn from the state for military service during the same time.

The figures given for the physician population are exact on the day of compilation. The only error would be an inconsiderable minus error particularly in the category of retired physicians, as there is a possibility that all of these have not been located.

# THE CHOICE OF A DIGITALIS PREPARATION

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THERE are four significant factors with respect to which digitalis preparations differ: (1) potency; (2) absorption; (3) speed of action; and (4) speed of elimination. They determine the choice of a digitalis preparation. Qualitatively their therapeutic actions are similar.

POTENCY

It is well known that specimens of digitalis leaf or tincture vary in their potency. Biological standardization of digitalis has endeavored to solve this problem. To what extent has it proved successful? The first method of assay used by the U. S. Pharmacopoeia was the frog method. However, many cardiologists preferred the cat method, and several preparations of commerce had adopted the non official cat method. The labels expressed the potency of the tablets or tincture in terms of "cat units." The Twelfth Revision of the Pharmacopoeia which became official November 1, 1942, dropped the frog method and adopted a modified cat technique as the official method of assay. The chief reason for the change was the discovery that the results with the frog method were sometimes misleading. Preparations were found which were only half-strength by the frog test but of full strength when tested in the cat and in man. At the present time all U.S.P. digitalis preparations are assayed by the cat method. The label, however, does not read in terms of "cat units" (except where the change has not yet been made) but in "U.S.P. units." When a tablet is stated to represent 1 U.S.P. unit of digitalis, it means that, when it and the standard digitalis are similarly injected intravenously in cats, the tablet produces the same effect as 100 mg. or 1½ grains of the "Digitalis Reference Standard" powder. Statistical studies show that testing a preparation against a standard enhances the accuracy of a bioassay. The U.S.P. unit represents approximately 30 per cent more digitalis than the so called "cat unit."

As the result of this new Pharmacopoeial cat method of assay, digitalis preparations on the market are likely to be more uniform than they were previously.

*From the Department of Pharmacology, Cornell University Medical College, New York*
*Presented at the Connecticut Clinical Congress, New Haven, September 28, 1944*

While matters are better than they used to be they are far from perfect. A few years ago we developed a method for the assay of digitalis directly on humans.[1] It now turns out that some specimens of digitalis leaf or tincture when tested against the standard by oral administration in man have a different potency from that shown in the usual test by intravenous injection in the cat. It is clear, therefore, that the U.S.P. unit may also prove misleading at times. Table 1 shows how far off it may be. While in many cases the answers are the same, in other cases they differ widely, and in the case of two specimens of digitalis having a potency of 1 U.S.P. Unit, one may produce 3 times as much effect as the other when given orally in man.

TABLE I

POTENCY OF DIGITALS MATERIALS BY DIFFERENT METHODS OF ASSAY

| PREPARATION | U.S.P. UNIT (CAT METHED) | U.S.P. UNITS (HUMAN METHOD) |
|---|---|---|
| 1. Digitaline Nativelle | 1 | 5.55 |
| 2. Gitalin | 1 | 1.81 |
| 3. Indian Urginin | 1 | 0.51 |
| 4. Lanatoside C | 1 | 0.50 |
| 5. Digitalis Leaf | 1 | 0.56 |
| 6. Digitalis Leaf | 1 | 0.59 |
| 7. Tincture Digitalis | 1 | 0.76 |
| 8. U.S.P. XI Ref. Dig. | 1 | 0.80 |
| 9. Digitalis Tablets | 1 | 0.87 |
| 10. H.A. No. 9 Leaf | 1 | 0.87 |
| 11. Digitalis Leaf | 1 | 0.95 |
| 12. Dilgitalis Tablets | 1 | 0.97 |
| 13. Digitalis Leaf | 1 | 1.46 |

One reason for the different answers by the human and the cat methods is the fact that the human is an oral method and the cat an intravenous method. The intravenous method does not distinguish absorbable from non absorbable materials. A compound may be potent by vein but weak by mouth if it isn't well absorbed.

One should note in the Table that discrepancies between the cat test and human test are even greater in the case of purified glycosides. With these, one official U.S.P. unit may produce effects in man which vary from 0.5 to 5.5 units, a variation of about ten times. The U.S.P. unit is, therefore, without practical meaning in the case of purified digitalis materials by oral administration in man. The unit of one material may produce a therapeutic effect ten times as great as a unit of another material.

It is important to remember this fact when matters don't seem to go as they should in the cours of digitalization. The solution to this difficult would be the use of the human method of assay, bu the fact remains that the human method is not suff ciently widely used at the present time. The digital of the New York Heart Association is assayed b the human method insuring for the 60 membe clinics a degree of uniformity of the drug which not obtainable in any other way at the present time.

ABSORPTION

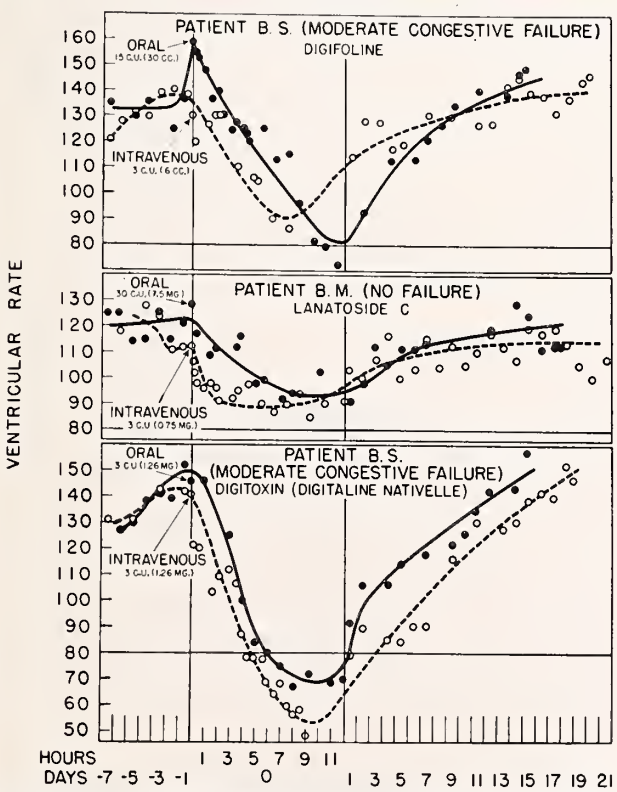
The next requisite for the choice of a digitali preparation is that it shall be well absorbed. Whe materials are slowly absorbed they are also likel to be irregularly absorbed, and that interferes wit the smooth course of digitalization. There is anothe point worthy of mention in this connection, namely that if a preparation is poorly absorbed, larger dose are necessary in order to secure the systemic thera peutic effect. These are more liable to produc nausea and vomiting from a local action. All digitali glycosides produce a local irritant action. If they are injected subcutaneously they produce very severe pain. They also frequently cause pain whe they are injected intramuscularly, although the loca effect here is not so great. The more of the glyco side that is taken by mouth the greater the likelihood of nausea and vomiting. The unabsorbed portion o glycoside contributes nothing to the therapeutic action but is there in the intestinal tract to add to the local irritant action. When one gives a dose of digitalis by mouth in the form of the leaf or the tincture, only about one-fifth is absorbed. The remaining four-fifths contributes nothing to the therapeutic action. We know this fact from the observation that it takes only about one-fifth as much digitalis by vein as by mouth to produce the same effect. One way, therefore, to find out whether a preparation is well absorbed or not, is to ascertain the ratio* between the oral and the intravenous dose in man. If the ratio is 1-1, the material is completely absorbed; if the ratio is 2-1, one half of the dose is absorbed; if the ratio is 5-1, one-fifth of the dose is absorbed. If a new preparation of digitalis, therefore, is brought to one's attention, one of the first questions which should be asked concerning it is: What is the ratio between the oral and the intravenous dose? Figure 1 shows how these matters stand with respect to a few of the digitalis preparations in common use. The ratio for digifoline is

*This ratio involves not only the factor of absorption but destruction and elimination.

about 5-1; for cedilanid about 10-1; for digitoxin 1-1. The choice of materials from the standpoint of absorption in this group is self-evident.

### SPEED OF ACTION

A third consideration in the choice of a digitalis preparation is the time it takes the material to develop its full action on the heart. I don't refer here to oral administration but to intravenous injection. Obviously, after an oral dose of digitalis the speed of absorption is the chief factor in determining the time it takes for the drug to produce its effects. However, after intravenous injection, the drug reaches the heart promptly and absorption is not involved, yet even under these conditions there are differences between digitalis glycosides in the speed with which they develop their full effects.[3] Figure 2 illustrates this phenomenon. After an intravenous injection of ouabain or crystalline strophanthin, all the effects that are likely to occur take place within about two hours. After an intravenous injection of digitoxin it takes about 6 hours for the full effects to develop. Between these two stand digifoline and cedilanid. It follows that in emergencies in which it is imperative to obtain the full effect quickly, ouabain by intravenous injection is the material of choice. This chart also indicates the appropriate interval between doses. After an intravenous injection of digitoxin there is little point in repeating the dose until 4 or 5 hours have elapsed, if the desired effects have not occurred earlier, because it may take as long as that for the full effects of the first dose to develop. On the other hand, the intravenous dose of ouabain, if need be, may be repeated within two hours.




EACH PATIENT WITH AURICULAR FIBRILLATION RECEIVED AN ORAL AND AT ANOTHER TIME AN INTRAVENOUS DOSE OF THE PARTICULAR PREPARATION. NOTE THAT IN ORDER TO PRODUCE APROXIMATELY THE SAME EFFECT IT REQUIRES FROM 5 TO 10 TIMES THE DOSE BY MOUTH AS BY VEIN. IN THE CASE OF DIGITOXIN, THE ORAL AND INTRAVENOUS DOSES ARE THE SAME.

FIGURE 1

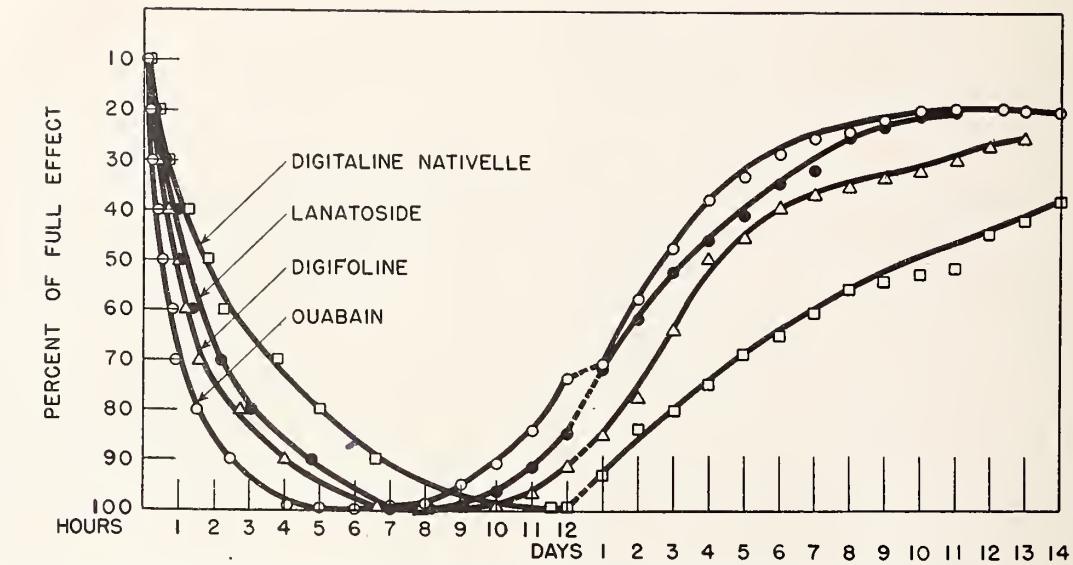
### SPEED OF ELIMINATION

Finally, speed of elimination is a deciding factor in the choice of digitalis preparations. On the whole, preparations which are slowly eliminated are most advantageous for ordinary therapeutic uses. One should note from Figure 2 that there are wide differences in the duration of action or speed of elimination of digitalis materials. In the case of ouabain only about one-third of the effect remains at the end of four days, while in the case of digitoxin less than one-third of the effect wears off in four days. Since it is usually necessary to maintain the state of digitalization for a long time, it is much more satisfactory to use a preparation which is not rapidly eliminated.

### THE CHOICE PREPARATION FOR ROUTINE USE

Digitoxin is the preparation of choice for routine use.[4] It is completely absorbed from the intestinal tract after oral administration in man as shown by the fact (Figure 1) that it requires about the same dose by mouth as by vein. The average dose for full digitalization is 1.2 mg. This produces the effect of approximately 1.2 Gm. of digitalis leaf (see Figure 3). This dose may be given at one time in patients who have not had digitalis. The 1.2 mg. represents so little glycoside that nausea and vomiting from local irritant action is almost never encountered. One cannot give the therapeutic equivalent of 1.2 Gm. of digitalis at one time in a routine manner because about one out of five patients develop nausea or vomiting from local irritant action. You will recall that only about one-fifth of the dose of digitalis is absorbed, although all of it may serve to produce local irritation in the gastro-intestinal tract.

There are, of course, tolerant patients who require more than 1.2 mg. of digitoxin for full therapeutic effects as there are patients who require more than 1.2 Gm. of digitalis for similar results. After the 1.2 mg. digitalizing dose has been given, one may complete the effects and then maintain them by a single dose of 0.2 mg. given daily almost indefinitely. There are a few patients in whom it may be necessary to reduce the maintenance dose to 0.1 mg. and




EACH CURVE REPRESENTS COURSE OF HEART RATE CHANGE AFTER A SINGLE INTRAVENOUS DOSE OF 3 CAT UNITS. EACH POINT ON CURVE REPRESENTS AVERAGE OF ABOUT 15 PATIENTS WITH AURICULAR FIBRILLATION. NOTE THAT OUABAIN PRODUCES FULL EFFECTS IN ABOUT 2 HOURS AND DIGITOXIN (DIGITALINE NATIVELLE) IN ABOUT 6 HOURS.

FIGURE 2

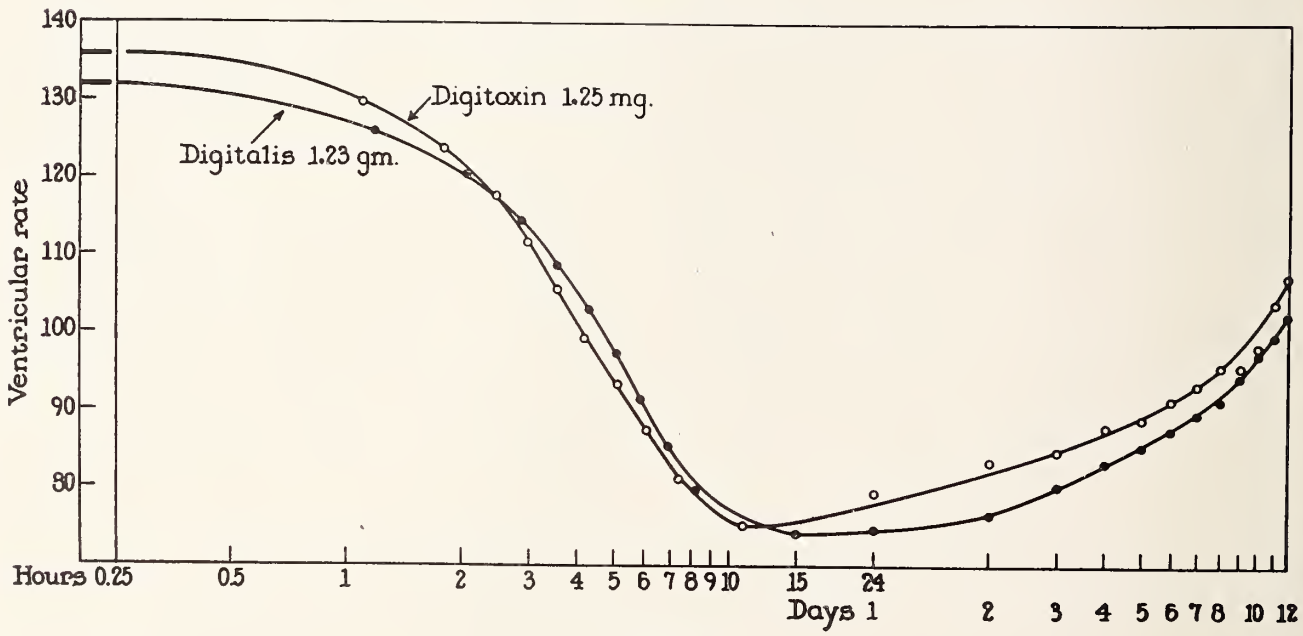



FIGURE 3

The curves show ventricular rate changes in patients with auricular fibrillation. Each curve represents the average of the results in several patients confined to bed. The dose was given at one time by oral administration. Time is shown in hours after the dose. Note that the curve of digitoxin action is essentially similar to that of digitalis.

occasionally to increase the dose to 0.3 mg.

By means of digitoxin it has become possible to digitalize a large proportion of patients with heart failure satisfactorily with a single dose in a period of about six hours in place of the divided dose method in which digitalis leaf is used and which takes from 24 to 48 hours to produce the same effects.

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# THE COMMUNITY HOSPITAL AND ITS OUT PATIENT CLINIC

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Hospitals of the future will undoubtedly be the medical centers of the community, and Out Patient Clinics of hospitals will increasingly become the valued training ground of the young physician, as well as the center of the hospital area for ambulatory and preventive medical care.

Out Patient Clinics have long been viewed with suspicion by many physicians as competitors of the private practice of medicine. The truly great value of the Out Patient Clinic, not only as a service to the patient, but also as an important economic and professional aid to the physician has been repeatedly demonstrated.

Adequate care of the ambulatory patient whose illness does not necessitate hospital bed care should be the prime consideration of the Out Patient Clinic. Those communities whose hospitals do not have an Out Patient Department must waste material, equipment, and the time consumed in 24 hour personnel coverage, to care for numerous patients whose real needs do not call for hospitalization. This constitutes an economic and professional waste, and, unnecessarily, increases the cost of medical care to the community.

Few, if any, of the present Hospital Insurance Plans make any provision for the payment of the Out Patient bill for the diagnostic workup or the therapeutic care of the patient. This one fact alone is still responsible for the unnecessary hospitalization of quite a large number of patients per year.

It is a well known fact that, in most places, under our present system of medical practice, with the exception of abnormal war time demands, the physically vigorous and mentally alert young M.D. must "mark time" and actually wait for his practice to develop. This situation constitutes not only a serious economic threat to this young professional man and to his family, but is also a shameful waste of medical manpower and ability. The properly functioning Out Patient Clinic can be a training center and proving ground for the recent medical graduate so that he may be both professionally and economically productive from the very beginning of his career. Many Out Patient Clinics follow a plan of apprenticeship for the young medical graduate. When his interest has shown itself to be sustained and his experience with numerous patients over a period of several years or more has made him more mature, he may then be graduated to the hospital Attending Staff. This promotion should be made exclusively upon the basis of training, ability, and merit, rather than being based upon seniority.

An important part of the training of the young physician in the Out Patient Clinic is the ease with which he becomes accustomed to ask for consultations with his fellow physicians in the clinic and from the clinic leaders. Information of great value to both the physician and his patient is thus easily and painlessly disseminated. This increasing fund of knowledge will automatically carry over into his own private practice.

Incentive for the young physician to keep abreast of the modern trends in medicine is provided by the discussions which are invariably found in clinics. In this connection it is wise to have, easily available, the best of the current medical journals so that constant help and stimulation from other medical centers may thus be available. It is important that these journals be chosen for their quality rather than for their quantity.

Out Patient Clinics are important sources of stimulation for the recording of group experience so that these experiences, when they become sufficient to have a significant meaning, may be published for the benefit of other physicians and thereby provide a stimulus for constantly improving the quality of medical care.

In the larger group of patients in the clinic the young physician will become accustomed to the

*Presented at the Hartford Medical Society November 15, 1943.*

efficient care of conditions which he may see only rarely in his own practice. For example, he may here see many diabetics in one year with resultant rapid improvement in his ability in this line. We may honestly inquire of ourselves whether or not we can learn to handle patients well when so few of this group are seen in the ordinary routine of private medical practice. In the clinic, also, certain phases of administration may be noted which will be helpful to the young M.D. in the management of his own practice.

It has been a common fallacy of the past to consider that Out Patient Clinic service should be rendered gratis by the physician. Thus a serious need has been overlooked both from the standpoint of the clinic and the M.D. The young physician would welcome, and could certainly use, $5 to $10 or more per morning or afternoon clinic session, for one or several sessions each week. If the clinic will provide positions with remuneration there will be an important additional incentive to punctuality and regularity of attendance rarely found in the present system.

In times of emergency, Out Patient Clinics can be converted into triage and treatment centers for the ambulatory or emergency care necessitated by any catastrophe involving illness or injury to large numbers of people.

The Community Hospital has both a privilege and a responsibility to sponsor and to provide postgraduate medical education. We are quite likely to think of this program as one which is restricted to interne training. In the true community hospital which is living up to its responsibilities, however, the postgraduate education of its attending staff is also of great importance. Then there is the stimulating vision of the future in which the community hospital becomes the true medical center, providing the opportunity of postgraduate training for any and every M.D. in the hosiptal area. This postgraduate training must utilize Out Patient Clinics in which the M.D. may work. Also there must be educational programs, ward rounds, and Clinical Pathological Conferences which he may attend. Teaching motion pictures must be provided, based on the educational dictum that "seeing is believing"—and remembering. The demonstration, repeatedly if necessary, of everyday as well as difficult techniques, in which the important "Do's and Don'ts" of medicine can be demonstrated clearly and thoroughly, will be a valuable educational weapon.

A splendid opportunity for postgraduate education sponsored by the community hospital will present itself when our young medical men return to us at the termination of the present conflict. We should plan now, and be prepared to offer practical refresher courses since many of these men will have been quite out of touch with many phases of medical and surgical practice for periods of months or years. This task will be much too large, quantitatively, for the medical schools of our country, nor are they alone fitted to perform this task. We should then feel that it is our community responsibility to provide not only refresher courses but a place in our Out Patient Clinics where these men may again rapidly regain their confidence and usefulness, professionally and economically.

We have been talking of the Community Hospital, its Out Patient Clinic, and the care of the patient. The results of the future of medicine depend upon our willingness to assume the responsibility of leadership in a plan of attack based upon the improvement and strengthening of our own professional ability with the aim of improved medical care for all as our constant and *urgent* goal. That profession which does not heed and keep pace with social evolution is quite likely to find itself gradually, but inevitably, dominated and controlled by those social and political "reformers" who are riding the crest of the wave of popular demand. Let us not, then, be guilty of fighting a delaying rear guard action, but let us rather use our intelligence, professional knowledge, and ideals to be leaders of the vanguard in the improvement of the quality and proper distribution of medical care.

# A CONNECTICUT PLAN FOR THE CHRONICALLY ILL

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N THE field of health, as in other sciences, the solution of one problem gives rise to new problems. ledical science has succeeded in removing or, at ast, controlling many diseases which shortened an's life span and annually ended the lives of a rge percentage of the population. The layman is ldom aware of the social progress which has re-lted from the successful solution of the problem acute disease, even though this solution has been ost remarkable and effective during the life span of e present older generation. What the layman sees, hen he considers the health of his society, is a ountainous problem of long term physical impair-ent and disability; of disease which does not kill, it which prevents the efficient use of talents and ills and the enjoyment of a normal social life in e latter decades of life. These disorders are the new oblems that have arisen with the increased life an. The layman sees not only that chronic illness ay incapacitate him, but that all the savings from s life's work may be spent in the futile effort to cover normal health. Unaware that the "doctor" is not had a chance to draw his breath since his first signment to save life, the layman is now asking, metimes with impatience, why he hasn't done mething about these chronic diseases. The doctor n only reply that he has just recently been able to art work on this problem but that he is confident success if he is given time and cooperation, since ntrolling and preventing the chronic illnesses is ore than a medical task; it is a problem for all of ganized society.

So it was in an effort to get some of the prelim-ary non-medical groundwork done as a preparation r the medical attack on chronic illness in Con-ecticut that the 1943 General Assembly directed e Public Welfare Council to make a study of the oblem and to report its findings in 1945. In Janu-y, 1944, the Research Division of the Council began its work and a preliminary article on the project was carried in the February, 1944, issue of the JOURNAL.

This study was not limited specifically to any age group, though the social problem is more acute with the aged, but the data collected were practically limited to the economically or medically indigent groups in the population. While medical science makes no distinction between chronic illness in the millionaire and pauper, the state has a direct responsibility for those whose resources do not provide them with a minimum level of civilized living. It was, therefore, with this latter group, exclusive of those patients of the institutions for the blind, deaf, tuberculous, and mentally ill and defective, that the study was primarily concerned.

Also omitted from this study were the complex problems of chronic alcoholism and drug addiction, though they logically belong in this field of endeavor. It was felt that, for most efficient social action, they should not now be included with the other chronic disorders which more clearly need medical care. It is recommended, however, that the General Assembly order a thorough study of the problems of alcoholism and drug addiction with a report to be made for action by the state in 1947.

Those readers who wish a description of the planning, methods of work and detailed statistical analysis of the findings are referred to the published report of the Public Welfare Council.[1] It should suffice here to say merely that within certain known limitations the findings of the study are accurate.

1. During the course of the work, frequent consultations were held with members of the following Medical Advisory Committee, who gave generous and thoughtful advice: James Raglan Miller, M.D., Hartford, Chairman; Wilmar M. Allen, M.D., Director, Hartford Hospital; Creighton Barker, M.D., Secretary, Connecticut State Medical Society; H. Gildersleeve Jarvis, M.D., President, Connecticut State Medical Society; Eugen Kahn, M.D., Yale University School of Medicine; George M. Smith, M.D., Yale University School of Medicine; Charles H. Sprague, M.D., Chairman, Veteran's Home Commission.

It should be realized, however, that the picture presented by the study is not a static one. Thousands of the chronically ill are now employed but, if our peace time economy does not maintain an equally high level of production, they will become sub-marginal workers and will eventually appear on public assistance rolls. Thus, if this study had been done when a larger proportion of the population was indigent, it may be assumed that a larger number of chronically ill would be found. If a thorough study of the whole population were made, it is probable that 100,000 cases of chronic disorder would be found.

Briefly, about 20,000 chronically ill adults were found on the rolls of the various public assistance agencies. Three-fourths of them appear to have two or more illnesses, though in many cases two reported illnesses may be different aspects of one underlying disorder. The most frequent diagnoses found were, in order, heart disease, arthritis, diabetes, diseases of the eyes and extreme "feebleness due to age." Over half are women, and half are aged 68 or over. While the median age is high, all ages are well represented in the totals.

Of the 20,000 chronically ill adults, over 2,000 are bedridden and about 7,000 are only partially ambulatory. Of these two most disabled groups, 1,000 are living alone, 4,500 are with members of their own families, 1,400 are in boarding homes, 900 are in private chronic and convalescent hospitals, 300 are in general hospitals and over 900 are in town farms or municipal homes. Thus, about half of these 9,000 most handicapped patients are now separated from their own relatives.

The medical problems of this group of patients are quite different from those of the self-supporting population in that complex social and economic problems are involved in their care. It would be a very superficial solution which would propose telling these thousands of patients to seek medical care from their local physician or hospital, with the provision that costs would be borne by the public assistance agency, for it is well known that even the most enlightened, and those to whom medical costs are no obstacle, do not seek and get as much medical care as they should have. For medical care and positive health programs to be effective, the following conditions have to be understood and handled intelligently.

1. Ignorance, apathy and actual negativism on the part of patients concerning their health needs.

2. Ignorance regarding, and lack of integration of, community resources at the level of direct dealing with the patient.

3. Lack of sufficient physicians, medical workers, clinics, hospitals and diagnostic facilities.

4. Cost of adequate medical care.

Intelligent handling of these factors will require the willing cooperation of physicians, health agencies, community resources, government, and the patients themselves, and it will have to develop through a program which gives full recognition to existing facilities and which does not arbitrarily set up new procedures without regard for existing practices, traditions and attitudes. The usual "cultural lag" between science and theory on one hand and existing conventions on the other, is due neither to specialization in the former nor ignorance in the latter, but to the lack of effective integration of these two on the working level of dealing with actual social problems.

The following recommendations by the Public Welfare Council are not claimed to represent this desired effective integration, but they are presented, after careful consideration, in the hope that they will serve as a meeting ground for discussion and criticism by all those persons and groups whose cooperation can represent a very major step toward the solution of some of these problems. Within the scope of the Council's knowledge, both of the chronically ill and of the agencies and resources mentioned, these recommendations appear to be merely common sense approaches.

The separate recommendations are thought of as operational approaches to the one fundamental problem of marshalling all resources for the provision of better health at a reasonable public cost. They are predicated upon centralized administration but decentralized operations and services.

First, a commission is desired to administer the program. The commission is to represent all pertinent interests and its policies are to be carried out by one chief executive.

At the first level, a mechanism for providing as much care as possible in the patient's home is necessary. About 12,500 now live in their own homes or with members of their families; 2,900 live alone. The plan for this group envisions four major resources or services:

1. Visits and treatments by local family physicians in the home or office with payment on a fee for service basis.

2. As an aid, both to physician and patient, outpatient clinic facilities should be established or expanded. These clinics should serve about 6,000 ambulatory patients, giving consultation, diagnostic services and some treatment. Clinic services, when provided by private hospitals and agencies, might be paid for by a combination of grants-in-aid and fees for service.

3. Care in the home, under the direction of the physician, should be given by public health nurses from community agencies. These agencies should be paid on a fee for service basis just as is now done with physicians. At the present time, there are about 525 positions for public health nurses in Connecticut. At least 350 more are needed and a larger percentage of all nurses would be needed for bedside care in the home.

4. A system of housekeeping services, under the direction of the nursing agencies, would enable many patients to stay in their own homes rather than go to institutions for care and treatment. Such services could be provided by organized groups of housekeeping aides. Payment should be made, probably, through the nursing agency.

At the second level, a minimum of 3,000 infirmary beds are needed. Though it may be expected that most patients will need infirmary care over long periods of time, active medical, nursing, occupational and recreational therapy programs should result gradually in admissions nearer the onset of the disease, with better prognoses, and therefore in increased discharge rates. There should be five of these infirmaries located in the regions of Bridgeport, New Haven, Waterbury, Hartford and Norwich.

At the third level, 1,000 new hospital beds for treatment of the acute and operative phases of chronic diseases are needed. Examples of such services are diagnoses in problem cases which need special and intensive laboratory facilities, cancer treatments and surgery. These new beds should be provided in such of the present general hospitals of the state as can meet the standards and requirements of the commission or in new state hospitals built and administered by the commission. The Public Welfare Council does not recommend either system to the exclusion of the other as this question is one that must be answered by medical and governmental authorities on the basis of medical care and comparative costs. Perhaps both systems should be adopted and a certain portion of the 1,000 beds provided in one state hospital where most effective treatment of some diseases, such as cancer, might be provided, and where a unified program of research, training and specialist treatment might be more effective and less costly than would be the duplication of such work in the many general hospitals. If one such state hospital were built it should be located adjacent to an active medical center so that most effective use might be made of consultant specialists and of facilities for research and training.

In addition to the medical care programs outlined above, there is a large group of indigent aged who are in desperate need of better living facilities. Though most of them might be strictly considered to be chronically ill, there is no known way of treating them and they do not present recognized problems for specific medical care. Five new state boarding homes for the aged are needed to accommodate at least 1,000 persons. These boarding homes should not be custodial institutions but should operate on the principle that they are merely temporary homes pending the arrangements for private living quarters whenever possible. These homes should provide some suites for married couples and facilities for occupation and recreation.

The above recommendations represent a minimum program. They do not include, however, one additional step that is necessary if the problem of chronic illness is not to be allowed to assume greater and greater proportions and, consequently, insupportable public costs. This additional requirement is a research and educational program that will make full scientific and practical use of the proposed agencies and facilities toward the prevention of these chronic disorders. The alleviation of suffering and even the cure of the patients of these diseases, when possible, are not enough. The most ambitious program of research which eventually results in the prevention of these diseases would cost but a small fraction of the total costs and economic losses now due to these chronic diseases. Research and training funds should be provided the commission but additional grants should be secured elsewhere because the benefits of whatever progress might be made in Connecticut would not be limited to state or even national boundaries.

This program may appear to be a large and ambitious one because of its subdivisions, but its estimated cost is low in proportion to its benefits. It is impossible to predict with any accuracy the post war costs of building materials and labor, the extent to which present structures might be converted for use

and the extent to which federal aid will be available for both the building construction and the operation of the program. On the basis of past costs for the sort of services projected in these recommendations, it is probable that the operation of the whole program, including depreciation and amortization of capital costs, would add about $1,000,000 to the state's annual appropriations for health and welfare. It is felt that this expenditure of public funds will constitute a paying investment if the recommendations are carried out with due emphasis upon the best medical standards, as well as upon operating efficiencies.

With the knowledge that we now have of the incidence and the measures necessary for the treatment and care of the chronically ill, and a concerted effort on the part of all the agencies concerned with the problem to expand this knowledge, and with the splendid example of accomplishment in the control of communicable diseases, it is our conviction that the recommendations offered in this report will provide a basis upon which the medical profession and its co-workers can go forward to a complete control, not only of the diagnosis and treatment of the chronic illnesses, but of the much more to be desired prevention of such conditions.

# A VESTED INTEREST IN YOUR SOCIETY

One of the highlights of my term as president of your State Medical Society has been the inauguration of a campaign for $50,000 to secure a permanent home for the Society. Whether a suitable building already in existence is purchased or a new one erected will be for the Trustees of the Building Fund to determine. It must be sufficiently large to represent an improvement over the present quarters and of dignity commensurate with the prestige enjoyed by the Society. Moreover the investment must not over-step the limits of practical maintenance.

Because we who for various reasons do not find ourselves as part of the Armed Forces in this great war believe this is our obligation, we are not asking for contributions from our fellow members in uniform. The suggestion that each member be taxed seems to be the prevailing custom for obtaining funds today. It is not, however, the method which our forefathers pursued. Instead they dug deep down in their own pockets to share with others the little they had. This is a part of our true New England heritage.

Much has been written of the growing need of the Society for larger quarters, not only to house the Secretary's office as at present, but to include within its walls the editorial office of the Journal, the Treasurer's office, space for the Society files and working library, a safe for documents and records, an office for the Woman's Auxiliary and one for the Tumor Committee which is now housed in the New Haven Hospital. Many of the other committees would appreciate the opportunity of a central office and all would enjoy conference rooms designated for their use. A small auditorium for the House of Delegates is one of the possibilities which might be included. If space permitted it is conceivable that many of the interests closely related to medicine might be housed with us under the same roof.

These are the possibilities. Letters are coming in from our members overseas giving evidence of their interest in our Society and in the problems of the postwar world, medicine among them. The Council and Trustees of the Building Fund believed in the project sufficiently to start the campaign with gifts and pledges amounting to $6,000. The opportunity is yours to complete the amount and attain the desired goal. I bespeak your support.

H. Gildersleeve Jarvis, *President,*
*Connecticut State Medical Society*

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# EDITORIALS

## Logan Clendening
### 1884 - 1945

Logan Clendening who died at his home in Kansas City on 31 January 1945 after the manner of Seneca was one of the picturesque figures in American medicine. Members of the Connecticut State Medical Society will not soon forget the scholarly and amusing address which he gave in Middletown at the 150th anniversary celebration of the State Medical Society in 1942.* His broad interests in the history of American medicine made him known to the profession in the State as did his honorary membership in the Beaumont Medical Club. Wherever Clendening moved he became a center of interest—often a storm center. He enjoyed controversy and the quickness of his wit generally gave him an easy advantage over his adversary. He read widely in literature, medicine, and science, and during the last fifteen years of his life became one of the foremost collectors not only in the field of medical history but in English literature and travel. He was irresistibly fascinated by the Shakespeare-Bacon controversy, as well as by the Ireland forgeries, and his collections of Dickens and Sherlock Holmes were second to none. His amusing *Handbook to Pickwick Papers* (1936), although written in a lighter vein, portrays his extensive knowledge and scholarly appreciation of the great British novelist.

Clendening was born at Kansas City, Missouri on 25 May 1884, the son of Edwin McKaig Clendening, a city official, and his wife, Lide Logan. He attended the University of Michigan (1903-05) and obtained his M.D. from the University of Kansas in 1907. In 1914 he married Dorothy Hixon of LaCrosse, Wisconsin, a woman of talent and resourcefulness who shared her husband's literary interests and aided and abetted him in bringing together his considerable

*Resistance to change as a contribution to medical progress. CONNECTICUT STATE MEDICAL JOURNAL, 1943, 7, 519-526.

library. In 1939 Mrs. Clendening presented to the University of Kansas the Hixon Laboratory of Medical Research, which in addition to offering unusual scientific facilities also provided a roof and most attractive accommodations for the medical historical collection which Clendening had already presented to the University. Students at Kansas have found in the Clendening Library a place away from the hurly-burly of their crowded curriculum where they can commune with the past and absorb something of the life and work of the great figures of medicine. The wisdom and imagination of this gift will bear fruit in the years to come, and the authorities at the University of Kansas, while profoundly distressed over the untimely death of their Professor of the History of Medicine, will take satisfaction in knowing that his wife is alive and well and able to carry on, as did Lady Osler at Oxford, something of the tradition which her husband had brought to the School.

Logan Clendening is not an easy man to portray. He was full of conflicts and inconsistencies, but he had an abiding devotion to the medical profession in the broadest sense. He wrote extensively and through his syndicated column on medical subjects exerted as great an influence on lay thought as any individual in this country. He also wrote a number of widely used professional and semi popular texts, including *Modern methods of treatment*, 1924, which has passed through eight editions; *The human body*, 1927, which has passed through five editions; *The care and feeding of adults*, 1931; *Behind the doctor*, 1933 (2 ed. 1943); and a voluminous *Source book of medical history*, 1942. During the past two years he has given a series of unusual lectures at Kansas on medical logic which he had planned to collect and publish.

Apart from his writings, Clendening's medical career was not particularly eventful. After an internship he began general practice in Kansas City in 1909 and during the following year was appointed Instructor in Internal Medicine at the University of Kansas, a post which he held until the beginning of the last war. He was commissioned in 1917 as Major in the Medical Corps and Chief of Medical Service at the Base Hospital at Fort Sam Houston, Texas (1917-19). In 1920 he was promoted to the rank of Associate Professor of Medicine at Kansas and in 1928 was made Professor of Clinical Medicine, which post he held until his death. During recent years he has devoted less and less time to clinical teaching, more to writing and travel; but until the end of his life he remained a great clinical teacher who captivated the imagination and enthusiasm of his students.

Clendening made a point of visiting all important medical shrines, and his travels for this purpose carried him to Central and South America, to every country in Europe, and to many points in North Africa. Mrs. Clendening generally accompanied him on his travels and as a skillful photographer she did much to help complete the record. It is hoped that she will feel inclined to complete and publish his Gazeteer of Medical History. Clendening was an avid note-taker and, despite a certain gaiety and seeming indifference to some things that mattered in life, he seldom missed anything. Like a man asleep during a parliamentary debate, he would open one eye at the critical moment and give forth the appropriate quotation which the speaker had forgotten. Clendening's memory for literary allusions was uncanny, and the appropriateness of his casual story or citation to a given situation was the envy of many who have occupied a prominent position in public life. Because of certain intemperate enthusiasms and a Rabelaisian wit that sometimes lacked restraint, there were some among his colleagues who failed to take him seriously, usually to their regret; for if they crossed swords with him, whether late at night, early in the morning, or in broad midday, they usually did so at their own expense.

Few men of the medical profession in this country have had a finer quality of mind or an intellect more richly stored. Those who understood him loved him, and they also admired him for this fact—that although well endowed with the things of this world, as well as with the things of the spirit, he continued to work and be productive until the day before his death. Through his broad human interests in literature, art, and medicine, Logan Clendening became one of the foremost literary physicians of this country—a worthy companion of Jacob Bigelow, Oliver Wendell Holmes, William Osler, William S. Thayer, and his own much beloved colleague at Kansas, Ralph Hermon Major.

J. F. F.

## The Care of the Aged and Chronically Ill

The report of the study by the Public Welfare Council for a state infirmary for aged, infirm and chronically ill persons which is so ably summarized

for us by Dr. Heiser is a matter of far reaching significance for the medical profession of Connecticut. The report recognizes at the outset that the proper concern of the State is the health and welfare of all of its residents and that the present problem is a primary interest in furnishing medical and other facilities to those of our citizens who are chronically ill and aged and economically dependent. The authors of the report also recognize with real insight that the care of the indigent aged and the care of the chronically ill are closely interrelated and cannot be separated.

From a broad viewpoint four levels of medical care are suggested, home care, outpatient consultation for the ambulatory, infirmary care and chronic disease hospital treatment. Recognizing that proper and early diagnosis is essential even though expensive hospital beds may have to be used for observation periods the end result of such practice will be one of benefit both to the patient and to the economy of the program. To this end the report rightly states that "It is not true, as is so generally supposed, that nothing can be done to improve the condition fo the chronically ill," which means that in a well integrated program many of these individuals can be returned to their home communities and to normal social life.

With forward looking the report also emphasizes the importance and significance of a program of research on the causes of chronic disease and one which will include the training of physicians, nurses and social workers in this aspect of medical care. Aside from its economic aspects the scope of the program assumes proportions which from the medical point of view calls for the exercise of a good deal of imagination. We should remember however that the State tuberculosis program of which we are rightfully so proud had a similar incipiency.

As physicians we cannot forget nor must it be forgotten that right now our mental hospitals are being forced to take care of hundreds of physically ill persons who by no means belong in such institutions. The care of these unfortunate persons is the responsibility of the people of Connecticut as long as they desire to retain that independence of statehood which for so long has been a notable example. That the medical profession can be relied upon for full cooperation may be taken for granted for the devotion of our physicians to affairs having to do with public welfare is a matter of proud record. We congratulate the authors of this thoughtful and timely report and we would also congratulate the people of our State for the fine opportunity that is now theirs to demonstrate what community spirit and enterprise can do for a civilization in which such cooperation is so fundamental.

## The Coming Drive for Cancer Funds

The presentation in this issue of three papers having to do with the cancer problem is appropriate at this time for very shortly the Connecticut Cancer Society will cooperate in a National campaign to raise $5,000,000 by popular subscription. With the approval of the Council and with the support of the state cancer organizations the local Society hopes to raise $100,000 in Connecticut. An agreement relative to the division of funds raised in Connecticut has been reached by the American Cancer Society and the Connecticut Cancer Society. Accordingly the quota for the state is $100,000 of which $17,500 (the amount of the 1944 quota) will automatically be retained in the state. Fifty per cent of funds over $17,500 up to $100,000 will also remain in Connecticut and the balance will go to the national organization.

When physicians are asked about the drive it will be well to bear these facts in mind for it is certain that the excellent work on cancer now being done in our State will be profitably increased by additional funds with which to work.

## The Distribution of Connecticut Physicians

Dr. Barker in his study of the distribution of physicians in Connecticut presents more evidence that the war has brought into sharper focus problems that have to do with our national health. His analysis is not only important from an economical point of view, but it also has historical significance. In the consideration of sociomedical problems, both in the present and the future, data concerning the distribution of our medical manpower will be of great importance, and it seems certain that such studies should continue to be carried on if we are to plan wisely for the future development of medical practice.

## Annual Meeting of State Society Cancelled

The Council at its meeting of January 25 voted that the 153rd annual meeting of the Society which was scheduled to be held in Hartford on May 1, 2 and 3, be cancelled in compliance with a request

from the Office of Defense Transportation. The House of Delegates will meet in New Haven on May 23. This action will come as no surprise to our readers and was taken by the Council in order that our Society may live up to the spirit as well as the letter of the request from Washington.

Arrangements had been very nearly completed for the Hartford meeting but with the difficulties of hotel accommodations, even though the amount of railroad travel involved would be very small, it will be evident to all that the exigencies of the times demand such a step. More than ever we shall turn to our smaller group meetings and to medical publications for the latest developments in medicine. It is a small price to pay compared to what our members in the Armed Forces are sacrificing.

## Safest

Somewhere in this state lives a little girl between five and fourteen years old, she is the safest person from accidents in the United States. She is not a real little girl but is a statistical figure and there are thousands of her here.

This is all shown in the 1944 edition of "Accident Facts," the statistical yearbook on accident figures published by the National Safety Council.

Connecticut was found by the Council to be the safest state in the Union last year in terms of all types of accidents. The figures show that the age group five to fourteen has the lowest accident rate of any, with little girls getting hurt much less than little boys in the same age group. This young "Miss Connecticut" knows how to take care of herself.

## Dr. Howard P. Serrell of Greenwich Awarded Silver Star

On January 25 the Associated Press reported the award of the Silver Star to Howard P. Serrell of Greenwich for "meritorious service" in France. News of the award reached Mrs. Serrell in a telegram from the War Department.

Major Serrell, who practiced medicine in Greenwich for eight years before joining the armed forces as a captain in November of 1942, was decorated, the War Department telegram said, for "voluntarily flying into besieged Bastogne on Christmas Day to render medical aid to the U. S. forces there."

Accompanied by a medical corpsman, the telegram said, the major flew into Bastogne in a small plane accompanied by four U. S. Army Air Corps pursuit ships as guards. Throughout Christmas Day he performed 20 major operations "saving many lives."

The next day, the department telegram said, other surgeons were flown into the beleagured town where they remained actively engaged until men from Lieutenant General George Patton's Third Army reached the town.

Major Serrell also took part in the D-Day invasion of Normandy.

## Roger Downs Dies In Service

Lieutenant Roger Sherman Downs of the medical corps of the United States Navy, who formerly practiced in Litchfield, died in New York on February 6 at the home of his father-in-law, Dr. Harry Emerson Fosdick.

Roger Downs was commissioned in the regular medical corps of the Navy three years ago and for the past two years has been on duty in North Africa, Sicily and Italy. His training in the Navy included diving and underwater salvage. On his return to the United States about two weeks ago he was assigned to duty with the Third Naval District Headquarters, New York, and with Mrs. Downs was living with her father. He was found dead in bed from an apparent attack of coronary thrombosis.

Dr. Downs was born at Saratoga Springs in 1910 and graduated from Williams College in 1932 and from the Harvard Medical School in 1936. After serving as an intern at the Strong Memorial Hospital, Rochester, he completed a fellowship at Peter Bent Brigham Hospital, Boston. He first settled in practice in Farmington, later removed to Litchfield.

Lieutenant Downs and his wife, Dr. Elinor Fosdick Downs, were both members of the Litchfield County Medical Association and Dr. Elinor Downs is a member of the Committee on Public Relations of the State Medical Society.

## Call for Easter Seals

Once again the season of the Easter Seal Sale draws near. The Connecticut Society for Crippled Children and Adults stands in need of increasing support to carry on its ever widening program.

Servicemen are already returning from war. And many disabled veterans are finding their first cure and treatment in service hospitals. Some will come away restored, but others, healed as much as medicine can heal them, will need physical or occupational therapy to fit them for their old jobs or to help them adapt to new ones.

During the past year, the Connecticut Society for Crippled Children and Adults carried on a demonstration program of occupational therapy for veterans at Rocky Hill Hospital with such success that the project has been taken over by the hospital to be continued on a permanent basis.

This same work can be done for veterans, as it is done for other handicapped adults, in the Society's four Rehabilitation Workshops in Hartford, Bridgeport, New Haven and Stamford. The Stamford Workshop was opened in October and is the first Workshop in the state to offer physical therapy as well as occupational therapy.

It is in Stamford that monthly clinics are held under the Society's auspices by Dr. George C. Deaver of New York for patients from all parts of the state, referred by their own physicians. Dr. Deaver, an expert on physical re-education and rehabilitation, has been teaching his new techniques to doctors, nurses and technicians in charge of Army Air Force casualties.

The Society is offering a new service—a craft program for homebound cases, in which a director experienced in merchandising visits patients to find out what craft activity is most suitable for needed therapy, to help supply them with materials and ideas, and to find a definite outlet for their work so that, even though confined, they may feel they are making a financial contribution to their livelihood.

It is also continuing its many other services through all its workshops: Vocational and educational guidance through aptitude tests and counseling; providing hospitalization and transportation to school or clinic; the purchase of needed braces, crutches and other equipment; a start on an educational program for some; a new attitude and hope and feeling of capability for all.

It is estimated that there are some 9,000 crippled persons in Connecticut in need of such help. Physicians knowing of such cases are asked to get in touch with the Society's state headquarters at 65 Wethersfield Avenue, Hartford.

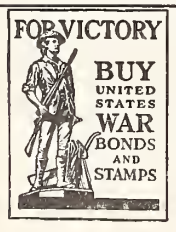
Everyone is asked to contribute to this essential program through the purchase of Easter Seals in the drive which will open March 1 and continue until Easter day. The Society's whole income is derived from this campaign.

## State Tuberculosis Association Sponsors Joint X-ray Project

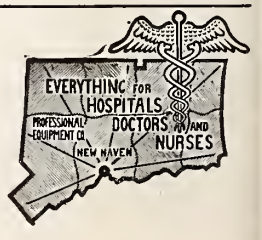
During the past year 32 local associations and a few individuals have contributed to the State Association for a special "Industrial X-ray Fund" to be used throughout Connecticut to sponsor mass x-ray projects in cooperation with the Department of Tuberculosis Control, State Tuberculosis Commission. The goal of the fund has been set at $5,000.

A special committee of three officers of the Connecticut Tuberculosis Association has been set up to handle the project. Dr. Paul S. Phelps, director, Department of Tuberculosis Control, has outlined policies for administration of a program to further x-ray examinations. The fund will supplement the present case-finding program of the commission in communities where facilities are not readily available or industries are not able to finance x-ray costs.

It is hoped that the additional $600 will be received by the Connecticut Tuberculosis Association within the next few months and the program put into operation.




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(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## COUNCIL CANCELS 153rd ANNUAL MEETING

The Council of the Society, at a special meeting held on January 25, voted that the 153rd annual meeting of the Society which was scheduled to be held in Hartford on May 1, 2 and 3, 1945, be cancelled in compliance with a directive from the Office of Defense Transportation. No formal request for permission to hold the meeting was filed with the Office of Defense Transportation in the belief that the Society should cooperate in full with the government directive that conventions of more than 50 persons be cancelled to further the war effort. One of the questions included in the form requesting permission to hold a convention was, "In what way and to what extent will the war effort suffer if this meeting is not held?" It was the opinion of the Council that this question could not in good faith be answered to substantiate the necessity for holding the Society's meeting. This action, cancelling the meeting for 1945, is being taken by the American Medical Association and many state societies.

The annual meeting of the House of Delegates for the transaction of necessary business will be held in New Haven on May 23.

### The Federal Crippled Children's Program

The Chairman of the Council presented a report from the Medical Advisory Committee of the Connecticut Program for Services for Crippled Children at the special meeting of the Council. This report is discussed at length elsewhere.

### The Control and Handling of Invested Funds

A report from the Special Committee on Invested Funds, consisting of James R. Miller, H. Gildersleeve Jarvis, Arthur B. Landry and Hugh B. Campbell, was received. It recommended that appropriate steps be taken to engage a bank or trust company to serve as a fiduciary agent for the Society and that the Council act as a committee of the Society to serve in all matters of the investment, control and disposition of funds of the Society and that the Executive Secretary and the Custodian of the JOURNAL Funds be each personally bonded in the sum of $5,000 in behalf of the Society.

### Section on Dermatology Reviews Legislation

A special meeting of the Section on Dermatology was held at the Society's office on January 16 for the purpose of discussing legislation to be proposed limiting the use of x-ray and radium for therapeutic and cosmetic purposes. The measure is now pending before the Connecticut General Assembly, S.B. 129.

### Medical Advisory Committee to the Crippled Children's Program

The Medical Advisory Committee to the State Crippled Children's Program met at the Society's office on January 24 for the purpose of discussing the new federal regulation relative to the admission of children to Crippled Children's Clinics. Members of the Society other than those who are members of the Advisory Committee were invited and there were present: Paul P. Swett, Chairman; James R. Miller, Chairman of the Council; Stanley H. Osborn, Commissioner of Health; Martha L. Clifford and Louis Spekter of the State Department of Health; Howard S. Colwell, Chairman of the Society's Committee on Public Health; Daniel C. Patterson, Karl T. Phillips, Robert Salinger, Edward T. Wakeman and the Secretary. The action of the Advisory Committee disapproving operation of Crippled Children's Clinics under the new directive of the Children's Bureau of the United States Department of Labor was transmitted to the Council.

### Committee On War Participation

The Committee on War Participation met in New Haven on January 24 under the chairmanship of

Ralph E. McDonnell. In addition to Dr. McDonnell there were present: Charles H. Sprague, Fairfield County; John F. Kilgus, Litchfield County; Edgar Fauver, Middlesex County; Edmund A. Douglass, New London County; Ralph B. Thayer, Tolland County; Ralph L. Gilman, Windham County; Lt. Comdr. William E. Neff, MC–USNR, Cheshire; Major Charles C. Verstandig, MC–AUS, New Haven, and the Secretary.

Commander Neff and Major Verstandig were asked to prepare a questionnaire that will be submitted to members of the Society upon their discharge from the Service to collect biographical and service data that will be incorporated in the Society's war record. Plans relative to the relocation of returning medical officers were projected.

## Committee On Industrial Health

Future meetings of the Committee on Industrial Health will be held at 7:00 P.M. on the fourth Wednesday of each month at the Graduates Club, New Haven.

## Committee On Post War Planning

The Committee on Medical Care and Health of the State Post War Planning Board, of which James R. Miller is chairman, met in New Haven on Thursday, February 8, for the purpose of discussing the report of the Pepper Committee of the United States Senate.

## Committee On Public Health

The Committee on Public Health, Howard S. Colwell chairman, met at the Society's office on February 15.

## Laboratory Evaluation Study

The Advisory Committee to the Evaluation Study of State Serological Laboratories, under the chairmanship of Mr. Friend L. Mickle of the State Department of Health, met at the Society's office on February 16.

## Physicians Recommended For Licensure

The Connecticut Medical Examining Board held a special meeting on January 31 for the purpose of passing upon credentials of four applicants. The following were found qualified and recommended for licensure:

Gerald P. FitzGerald, Tufts 1944, National Board of Medical Examiners. St. Francis Hospital, Hartford.

Robert H. Furman, Yale 1943, National Board of Medical Examiners. New Haven Hospital, New Haven.

Ciro Giobbe, Tufts 1930, Massachusetts license 1930. Somerville, Massachusetts.

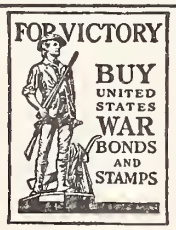
Mark Rittner, Tufts 1919, Rhode Island license 1931. Providence, Rhode Island.

## Red Cross Nursing In Connecticut

Connecticut has ten classes of Red Cross volunteer nurses aides currently in session. Thirty-four such classes have completed the course since July 1, 1944. Also since July 1, 1944, seventy-three home nursing classes have been completed in this state and one hundred six classes now are in session. The help of physicians is desired in encouraging enrollment of both men and women and by suggesting to the chapters, methods and means of making the course more sound and practical.

## Michigan Physicians Oppose "Social Insurance" Amendment

Because the physicians of Michigan believe the proposed "Social Insurance" amendment to the Michigan Constitution is dangerously contrary to the public interest, the Michigan State Medical Society is soliciting signatories to an agreement to decline to participate in the program if it should become law. The identity of the individual signatories to this agreement is to be kept confidential, only the wording of the agreement and the total number of signatories being released for publication.




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# THE GRACE-NEW HAVEN COMMUNITY HOSPITAL

On Thursday, January 25, 1945, plans for the union of the New Haven and Grace Hospitals were approved by the Board of Directors of the two institutions. This date will unquestionably be one of consequence in the annals of Connecticut medicine for there is every reason to believe that the consolidation of these hospitals, with their combined record of more than a century and a half of service in the community, will prove to be a contribution of major importance to the steady advance of medical and hospital practice in this state.

The community hospital of 850 to 900 beds which will be established through the consolidation, and which is tentatively named the Grace-New Haven Community Hospital, will make available to the population of New Haven and the surrounding areas increased hospital service of a high quality; it will provide for practicing physicians the means to care for their patients under conditions assuring the best diagnostic and therapeutic facilities and methods; and as a center of medical education and research, it will offer a notable opportunity for undergraduate and postgraduate training in medical fields.

Over a period of time, the disparity between supply and demand in hospital accommodations in New Haven has been gradually increasing, with the extension of hospitalization insurance, the growth of the population and the development of health education. The directors and the staffs of the New Haven and Grace Hospitals have long recognized this situation and have given careful consideration to the improvement and expansion of their plants and facilities in order to meet these needs. Each institution has been faced with its particular problems. The Grace Hospital plant is old and, were operation to be continued on the present basis, the replacement of many of its buildings would be required. In spite of plant deficiencies, however, the hospital has had an advantage in the favorable ratio of private, semi-private and ward beds. New Haven Hospital, which is affiliated with the Yale University Schools of Medicine and Nursing, has a modern plant and highly specialized facilities for diagnosis and treatment, training and research. It has, on the other hand, an unfavorable load factor because of the relatively heavy proportion of ward to private patients and, in order to adjust this ratio and satisfy urgent community requirements for the care of the sick, the addition of more private and semi-private rooms is necessary.

Thoughtful study of these problems by the governing boards of the hospitals led them to concur in the decision that the interests of the public and the institutions would best be served by the combination of present resources and the development and augmentation of these resources as a joint enterprise. An agreement was accordingly adopted which provides for the merger of the New Haven and Grace Hospitals and the formation of a combined hospital society, under the guidance of which there will be operated a general, community hospital in a single location. Legislative permission for the consolidation is being sought from the General Assembly now in session. It is not contemplated by the hospital executive committees, however, that the new institution will become a functioning reality until 1947 or later.

Under the stipulations of the present plan, the physical properties of the new hospital will comprise the existing plant of the New Haven Hospital and a large new building which will be constructed near it. The new unit will be a vertical structure of efficient modern hospital design and will have a capacity, according to the currently accepted estimate, of 400 to 450 beds. The proportion of ward to private accommodations now contemplated is approximately 1 to 3.5 or 4. With the accommodations at New Haven Hospital, there would then be made available in the project a total of about 900 beds, equally distributed among private, semi-private and ward quarters. Complete operating, x-ray and laboratory facilities, without duplication, however, of specialized equipment and facilities accessible through the School of Medicine, will make the building a self contained entity.

The Yale University Schools of Medicine and Nursing will be affiliated with the community hospital through a contract designed to preserve and extend the functions of the units in such a manner that each will supplement the other.

The merger of the hospitals will not impinge upon the nursing education programs of either the New Haven or Grace Hospital. The Yale School of Nursing will continue to offer training in nursing for college graduates, utilizing for practical application of nursing arts the beds assigned to the medical

school. The Grace School of Nursing, which will be operated in conjunction with the new unit, will adhere to its policy of admission of qualified high school graduates.

Overall supervision of the community hospital will be vested in a board of directors representing a merger of the present boards of the two institutions. The assets and liabilities of both hospitals will be pooled and endowment funds of each will be carried into the project without sacrifice of identity or loss of the original intent of the donors. Medical practice in the consolidated hospital will be governed by two different medical boards whose spheres of work will in no way conflict. Under this arrangement, medical board officers and professional staff who have the direction of the beds reserved for the teaching requirements of the School of Medicine will be appointed by the Board of Directors of the consolidated corporation on nomination by Yale University. Practice in the new unit will be supervised by a staff of physicians combining the interests now represented by the existing staff committee at Grace Hospital and the private pavilion staff committee at New Haven Hospital.

The University will contribute, as in the past, to the costs of operating beds which are used in the educational programs of the Schools of Medicine and Nursing.

The responsibility of establishing and maintaining medical standards and developing a program of training for interns and residents in the two units will rest with the respective medical staffs, which will nominate interns and residents for appointment by the Boards of Directors. The planning of curricula of instruction for returning medical officers who desire short or long term refresher or postgraduate courses before resuming community practice will also be under the direction of the staffs in cooperation with the University. One of the most cogent arguments for the coalition of the hospitals is the opportunity inherent in it for the development and extension of postgraduate medical instruction.

Medical service in the New Haven Dispensary will be in charge of the medical board of the medical school, but it has been agreed that interns, residents and junior staff men of the Community Hospital may be eligible to serve at the Dispensary. The new unit will also have a complete outpatient department which will be a valuable adjunct to the inpatient services in the practice of community physicians.

The funds necessary to finance the project will be solicited in a campaign which will be launched in the spring of 1945. The campaign goal is set at $4,000,000 and the drive will be under the management of the firm which conducted the successful hospital campaigns at Hartford.

The union of these two old and respected hospitals, each with a proud record of community service, is clearly an extraordinary opportunity to build an outstanding medical center, the benefits and influence of which will spread beyond the New Haven area most directly affected to every part of the state.

## Vocational Counseling Service, Inc.

Early this year there was incorporated in New Haven a non profit community organization for the purpose of providing professional vocational and education counseling, particularly designed to aid discharged veterans in finding the proper occupation. It comprises a board of eleven members, all laymen except Creighton Barker, executive secretary of the State Medical Society, each selected for a term of three years. If after a trial period of three years the service appears practical and important to the community, it is planned to establish a permanent organization. In addition to the Board of Directors there have been established several advisory committees to secure the participation and advice of persons and groups in the development of special phases of the Counseling Service. For example, there are committees on relationships with social agencies, with veterans, and one on training. Other similar committees may be established as need for them arises.

The Service proposes to make available both vocational and educational counsel to determine the training for and the occupational objective desirable or to determine the best educational placement of the individual. This latter service it is thought will be especially desirable during the immediate years to come because of Federal benefits to veterans. After service is established, and as need arises from the counseling centers in other towns of the state, Vocational Counseling Service will cooperate with educational institutions in the training of counselors through individual and group instruction on procedures of psychological counseling service, practice in giving, scoring and interpretation of tests and observation of counseling, or through the sponsor-

ing of institutes or similar procedures.

Services available as the Counseling Service begins operations will consist of the following:

A. CONFERENCE TO DECIDE IF COUNSELING IS NEEDED

It is understood, of course, that individuals, employers, school or agency personnel may and will personally or by phone discuss their problem with the acting director or other *Service* personnel, without charge or obligation, to decide whether or not *Vocational Counseling Service, Inc.*, can or should undertake professional counseling service.

B. COUNSELING SERVICE TO INDIVIDUALS

This service would find out from the client his background of training and experience, his interests and abilities, by information he supplied and by testing. This information would be interpreted by a trained counselor in the light of education and job opportunities. Counseling interviews would help the client to understand his abilities and limitations, to discover his best opportunities, to make his own decision as to what he should do, and to make the appointments with placement, educational or social agencies that can help him to secure the job, education or other assistance that he may decide he needs. Additional interviews would be needed by some and perhaps many clients to accomplish this. One follow-up conference (a month or so after the testing) is expected, both for the value to the client and for the Service personnel to check on the success of their counsel.

C. EMPLOYEE SELECTION COUNSEL FOR BUSINESS AND INDUSTRIAL FIRMS

This service would find out from the employer the kind of work to be done by the employee, provide for interview and testing to determine the abilities, interests and personal characteristics of prospective employees. The employee test and interview results would be interpreted by a trained counselor and a written report, supplemented by a conference, would be provided the employer.

D. COUNSEL AND TESTING SERVICE IN COOPERATION WITH SCHOOL AND AGENCY PERSONNEL

It is recognized that agency or school personnel, in working with individuals, may sometimes wish to have the advantage of information obtainable only through a comprehensive series of tests and the interpretations of the results of these tests by a psychologist. This service would make available to school and agency personnel psychological testing service and professional counsel in reference to individual children or adults with whom they are working. It would be presumed that for the most part the follow-up counseling of the client would be done by the school or agency personnel, and that Vocational Counseling Service professional staff would work mostly with the school or agency personnel.

The headquarters for Counseling Service, Inc., located at 30 Davenport Avenue, will be open on a part time basis at first, increased as requests for service so require. To start with, five experienced counselors of the Yale faculty have been secured for part time. The individual will be expected to pay for services rendered at a reasonable cost. Arrangements have been made so that individuals with limited means needing the service may be able to secure it. To this end funds have been secured which, it is hoped, will make this possible. No charge will be made for a conference to decide if counseling is needed. A charge of $20 is made for vocational counseling service, with special arrangements made for charges for service to veterans. In employee selection counsel for business and industrial firms, a charge of $20 is made per job for the employer consultation and analysis for one person tested as to fitness for the job. Each additional person tested is charged $10. For counsel and testing service in cooperation with school and agency personnel the charge is $20 to be paid by the client.

## Results of Industrial Nursing Course Cited

The first venture of the University's School of Nursing in Industrial Nursing Education can indirectly be traced to the interest in our problems shown by a joint committee on Industrial Nursing Education representing the Connecticut State Medical Society's Committee on Industrial Health and the Connecticut State Nurses' Association. Inspired by the study of this group, the Industrial Nursing Section of the Connecticut State Nurses' Association met with Mrs. Carolyn L. Widmer, Dean, School of Nursing, in 1944 and jointly sponsored the course which has just recently been completed. The course was made up of fifteen two hour periods with one period reserved for an examination. Successful completion entitled the nurse to two college credits.

The course, which was coordinated by an industrial nurse, used five industrial physicians, three industrial nurses and one safety engineer as lecturers, each having agreed to discuss a phase of the nurse's functions and problems. Two plants were visited to

demonstrate the various functions of the nurse, first a large plant to show specialization of duty and second, a small plant to show the variety of functions served by the nurse in the small plant.

Enrollment reached twenty-four industrial nurses representing eleven firms in an area extending from Manchester to Meriden. That twenty of these nurses completed a term paper, for presentation at a seminar discussion, demonstrated sustained interest. Fourteen of the original group submitted a written examinations as required for University credit, all of whom successfuly completed the examination.

In an open discussion at the close of the course all were agreed that as a basic course we had come near our objective; that we should go on and add more specific information about occupational hazards and diseases; that we should follow the pattern of utilizing diverse experience by using various lecturers; that the plant tours were worth while; that information concerning non occupational health problems justified greater emphasis; and that discussions of in-plant relationships would be very interesting (such as a two-way discussion between a physician and a representative of personnel management). Copies of the course outline may be obtained from the University.

In closing may we thank the following members of the Connecticut State Medical Society for actively and interestingly contributing to the success of the course: John N. Gallivan, Martin I. Hall, Andrew J. Jackson, Israel Otis, Crit Pharris, Charles F. Yeager.

Carolyn L. Widmer, R.N.
Dean, School of Nursing
University of Connecticut

Jesse C. Williams, R.N.,
Assistant Supervisor of Nursing
Pratt & Whitney Aircraft

## Danbury Area To Have Speech Services

As part of the State crippled childrens services, speech correction to children with harelip, cleft palate and cerebral palsy is now offered in the Danbury clinic area, starting Thursday, January 18.

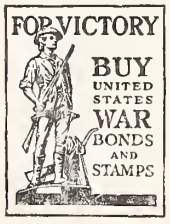
Patients referred for speech training are to be examined first at the regular monthly crippled children clinic. Following the clinic visit, a speech appointment will be made.

## Dr. Barker Broadcasts On the 4-F's

Early Sunday afternoon, January 28, our executive secretary's voice was heard on WDRC discussing the challenge of the 4-F's in the United States to the medical profession and to Federal, State and local government units. It was a timely broadcast, couched in plain terms which left no doubt in the listener's minds that we have a big job on our hands in future planning. Dr. Barker emphasized the effect upon the individual's initiative and endurance if the defect resulting in rejection is neglected. He reassured the public that the problem of distributing medical services and facilities so that they will be available in all sections of the country and to all classes of the population and the difficult but by no means impossible task of adjusting the costs of medical services could be worked out through the cooperative efforts of all concerned.

## Dr. Angus Leaves Institute of Living

Resigning from his position as associate psychiatrist at the Institute of Living where he has been a member of the staff for fourteen years, Leslie R. Angus has accepted the position of medical director at Bancroft School in Haddonfield, New Jersey, an institution devoted to the care and development of exceptional children. A graduate of both the arts and medical colleges at the University of Toronto, Dr. Angus came to Hartford after two years in private practice and one year in England. He has made for himself an enviable reputation while at the Institute and his interest in his profession has extended beyond the confines of the Institute. The sincere wishes of his many friends go with him to his new position.




MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE WAR

## 3,000 Physicians Needed in Navy

The need for Naval Medical officers is great. The fact that the Army has announced the suspension of procurement of physicians should not be interpreted to mean that the Navy is in the same position. We must face the truth; our rate of casualties has been increasing in recent months. Our men must have much needed medical assistance.

The Navy needs 3,000 additional doctors immediately. For that reason, we are making a special appeal to the members of the medical profession to assist us in every way possible. We fully realize the drain which has been imposed upon civilians. In many sections of the country the shortage of doctors is acute. Hard as this shortage is on tens of thousands of people, yet thousands of people must be asked to make sacrifices in medical care for their friends, relatives, and countrymen whose need for medical assistance is great.

All over the world Navy doctors are exposed to a training in medicine and surgery which is not only giving them a splendid chance patriotically to serve their country, but, at the same time, an opportunity to learn the more advanced techniques of the profession, working with men whose contribution to the field of medicine will be great both during and after the war. It is, therefore, earnestly requested that every physician give conscientious support to the medical needs of his community, to his responsibility to that community and to the war itself, and see if the best path for him to follow is to seek a commission with the U. S. Navy. Since the start of the war, physical requirements have been somewhat modified. Physicians are now accepted up to the age of 60. Men in the older age groups are assigned to hospitals, dispensaries and other Naval activities ashore.

Interested physicians, without making any definite commitment whatsoever, will be interviewed at their convenience at the Procurement and Assignment Service office, 258 Church Street, New Haven, Connecticut. Telephone 5-0836.

## How A Nurse Joins the Navy

Registered nurses seeking to become officers in the Nurse Corps, United States Naval Reserve, may now make application through the Office of Naval Officer Procurement at 33 Pine Street, New York. Inquiries in the past have had to be directed to the Surgeon General in the Navy's Bureau of Medicine and Surgery in Washington.

The aim is to speed commissioning in the corps, which is in urgent need of additional members. Under the new set up, a nurse will be notified of the Navy's decision approximately three weeks after the physical examination is given.

Other main and branch Naval Officer Procurement offices throughout the nation, cooperating with the local Red Cross chapters, have been directed to aid in the work. This procurement program carries a 1-plus priority, with a quota of 4,000 additional Navy nurses by June 30 having been set.

Application forms are now available at 33 Pine Street. Nurses are interviewed there, physical examinations are given and the various necessary documents collected for forwarding to Washington. Nurses in the city are asked to come to the Pine Street office; those out of town are asked to write.

Qualifications include the following: registered nurse, graduate of an accredited school of nursing; high school graduate; native born or naturalized citizen of the United States for at least 10 years; age 21 to 40; unmarried, widowed or divorced, preferably without minor dependents; member of a nursing organization affiliated with the American Nurses Association; physically qualified by standards set for naval officers.

## WAC Medical Technicians to Serve in Army General Hospitals

On 1 February 1945 WAC Recruiting Service went into a national campaign for the recruiting into the Medical Department of women who will be assigned to an Army General hospital.

General Marshall, U. S. Army Chief of Staff, has written a letter to Governor Raymond E. Baldwin asking him to sponsor this campaign in the state of Connecticut.

The Army is asking the State of Connecticut for volunteers for four (4) platoons of Medical Technicians to serve in the Oliver General Hospital, Augusta, Georgia, and in the Cushing General Hospital, Framingham, Mass.

With Army casualty lists steadily increasing and with quotas of nurses and technically trained Medical Department personnel critically short, the Army has begun a new and vigorous recruiting drive to enlist WACs for the newly created Women's Army Corps Medical Units. These units, to be made up of medical and surgical technicians and clerical workers, will aid in the care and rehabilitation of returned soldiers. For them 8,000 new WACs are needed immediately.

The plan for the units, as outlined by General Marshall is to assign a company of 100 women to each of the 1,000 bed hospitals and an additional company of the same size for each additional 1,000 beds in the larger hospitals. These companies will be made up of medical and surgical technicians (who perform widely assorted duties in the wards and operating rooms, under the supervision of Army doctors and nurses) primarily, but will include some women of clerical skill as well as x-ray, laboratory and dental technicians.

The accelerated training program for WAC hospital workers, the Surgeon General's office makes public, will run as follows: qualified women will receive six weeks of basic military training, six weeks training at an enlisted technicians' school, after which they will receive one month of applicatory training, will qualify as technicians with appropriate Army ratings and will continue on duty at the place of their final training.

Casualties are being returned from overseas to Army general hospitals in this country at the rate of 32,000 a month, General Marshall has announced. The Medical Department load is therefore higher now than it has ever been in the Army's history. For this reason the Army has set up one all-WAC enlisted technicians' school at Wakeman General Hospital, Camp Atterbury, Indiana, and has opened three other technicians' schools which had formerly been used to train men. These are Beaumont General Hospital at El Paso, Texas; Fitzsimmons General at Denver, Colorado, and Brooke General at Fort Sam Houston, Texas.

It will be at one of these four hospitals that a would-be medical or surgical technician will receive her six weeks' technical training. The all-WAC school at Camp Atterbury will also continue with its training of dental, laboratory and x-ray technicians.

1st Lt. Helen M. Roy,
Liaison Officer, State of Connecticut

## Army Aural Rehabilitation

Before a deafened soldier can be fitted properly with a hearing aid he must have a custom fitted ear piece to which the aid can be attached. Until now these ear pieces were manufactured by commercial concerns and some delay was involved due to the necessity of packing and transmitting the cast and receiving the ear piece by mail. Now, however, ear pieces of clear acrylic or lucite are to be manufactured in the three Army hospitals for the deafened—a step which means the soldier gets his hearing aid about a week sooner.

Each soldier-patient with impaired hearing is scientifically tested to ascertain precisely which hearing aid is best for him. Since variations have been found even in aids of the same model, a stock is maintained at the hospital so the soldier receives the aid which proved most satisfactory for him when tested. In addition to equipping the men with hearing aids, instruction is given in lip reading and speech correction, if necessary.

A great many cases of deafness among soldiers which passed undetected at the time of induction have since been detected through the modern scientific methods now in use by the Army Medical Department. These deafened, as well as those with service incurred deafness, are being rehabilitated at Deshon General Hospital, Butler, Pa., Hoff General Hospital, Santa Barbara, Calif., and Bordon General Hospital, Chicasha, Oklahoma.

## Veterans Administration to Fight Cancer

Cancer, according to *Victor News*, is becoming an increasing problem for the Veterans Administration. Although there is no evidence at present to indicate that military service contributes to the incidence of cancer, yet because the discharged veterans at the end of any war make it the largest single group in the general population, the incidence of cancer in this group is large. The Veterans Administration has six special tumor clinics and is planning another in addition. These seven institutions will have a total capacity of 2,100 beds. Since the average stay of a cancer patient in a hospital is about sixty days, it means a potential for treating 10,000 patients a year.

The Veterans Administration utilizes surgery, radium and deep rotengen ray therapy in treating cancer as do the other cancer hospitals. The Administration does claim certain advantages over civilian physicians:

1. The organization of veterans' groups makes it relatively easy for Veterans Administration to spread information to bring about early reporting of cases.

2. Physical examinations of Pension applicants on the claim of other disabilities makes it possible to detect cases which might otherwise be missed until too late.

3. Pension and other systems of Veterans Administration make it possible to keep close contact with cancer victims who have been discharged from hospitals, thus allowing a broader picture of the outcome of cases than is usually possible among persons discharged from private hospitals.

It is estimated that 750 to 1,000 new cases of cancer per one million individuals in the armed forces will appear each year. The admission of women to the armed forces poses another problem because of the addition of tumors peculiar to the female reproductive organs.

Several months ago *The Journal of the American Medical Association* reported that an average of twenty-two veterans of World War I entered hospitals of the Veterans Administration each day in 1941 with cancer. It predicted that twenty to thirty years from now about forty-five veterans of World War II will enter veterans hospitals daily.

## Importance of Preventive Medicine

War always spotlights the dramatic role played by surgery and medicine. Less frequently does some unusual situation shift the spotlight to the highly important role played by preventive medicine as, for instance, when our troops landed in the Philippines. There they found that the civilian population had suffered woefully for lack of a preventive medicine program under Japanese domination. Sanitation had deteriorated. Food was inadequate. Great numbers of the people were suffering from tropical ulcers, yaws, intestinal diseases and vitamin deficiency diseases. They were endangered by cholera, smallpox and typhoid fever. Now, with the return of our troops, preventive medicine is again being practiced in the islands. Carrying out plans prepared by the Civil Public Health Division of the Preventive Medicine Service, Office of The Surgeon General, sanitation is being restored. The people are being immunized against diseases. Health offices have been re-established in the majority of communities wrested from the Japs and dental clinics, dispensaries and hospitals have been established.

## Health of the Army In U. S.

During December the incidence of acute respiratory diseases in Army installations within the United States rose slightly, The Surgeon General's Office reports. The present incidence is much lower than in December 1943, when the influenza epidemic was in progress. In fact it will probably prove to be lower than any previous December rate in a number of years, although final data are not yet available.

A seasonal increase in pneumonia, mumps and scarlet fever is under way. For none of these diseases is the increase excessive. Measles incidence has not shown the expected increase, nor has meningococcal meningitis. The indications are that meningitis will be considerably less prevalent this year than last. The incidence of all diseases is lower than for December of the two preceding years but slightly higher than the December average for the period 1930-39.

### SKIN DIPHTHERIA

Lieutenant Colonel F. R. Dieuaide, Chief of the Tropical Disease Treatment Branch, Office of The Surgeon General, who recently returned from a three months' visit in three Pacific Theaters, reported a small epidemic of skin diphtheria in the New Hebrides which was brought under early control.

It is thought the epidemic arose from carriers, the bacilli usually being carried in arm or leg wounds from which the organisms could be transferred readily to skin lesions in other persons or to the throats of susceptible soldiers.

Individuals afflicted with this rare disease usually do not show serious effects, said Colonel Dieuaide, although neuritis sometimes develops and there are occasional heart disturbances. The symptoms generally disappear if the patient is put at rest, the lesions properly cleaned up, and a sterile, wet dressing applied. Penicillin has been used but it is not necessary, he said, unless other bacteria are present. A small dose of antitoxin is enough to protect most patients from any serious consequence to themselves.

The great importance of skin diphtheria, Colonel Dieuaide explained, lies in the danger that it may cause epidemics of ordinary diphtheria in soldiers, 45 to 50 per cent of whom are susceptible. The medical department has therefore taken prompt and effective steps to control the spread of the milder disease.

### RETURNING VETERAN WILL BE DIFFERENT

Soldiers who have been in combat two years will have aged ten years and their families and friends must be prepared to accept a difference in these returning veterans, Colonel William C. Menninger, head of the neuropsychiatry division of the Army Medical Department, said recently in the Laity Lecture of the New York Academy of Medicine.

There is little time to spare for communities to start making preparations for receiving the thousands of soldiers who will have to make readjustments, and serious ones, in adapting themselves to civilian life, Col. Menninger declared.

He emphasized that in discussing this subject of the return of the nation's Armed Forces he did not mean to imply that the war will soon be over. But in the meantime, he stressed, the problem must be faced of getting the soldiers back into a harmonious relationship with family and community.

"In addition to medical help," he said, "many veterans, perhaps most, will need other counsel. They will need 're-orientation' to civilian life, to the apparent business as usual status in the community, and to the family. This same counsel might well provide advice to wives and parents to help them understand his problems, to aid them in catching up with his premature aging, and be prepared to advise and cooperate with him in his plans."

"We know that many of these men will have difficulty in obtaining a job. No doubt the government can and will help, but fundamentally, men belong to a community—your town, my town. They belong to it and it should be the community's responsibility to organize a plan of survey, a counseling system, and an employee placement bureau."

Colonel Menninger related how Major General Norman T. Kirk, Surgeon General of the Army, gave the psychiatric program of the Army marked impetus by increasing the staff tremendously and making neuropsychiatry an integral part of the entire medical and surgical services in combat and in this country.

### ARMY NEUROPSYCHIATRIC NURSING SCHOOLS

Neuropsychiatric nursing schools are now in operation in five service commands and within the next few months will be established in all service commands in the United States. These schools offer a three month, on the job training course under the country's leading neuropsychiatrists. Enrollment is made up of Army nurses who volunteer for the training and a certificate of neuropsychiatric nursing is awarded each on completion of the course. At least two neuropsychiatry nurses are assigned to each general hospital in this country and to the staff of each general hospital organized here for service abroad.

### FIVE MORE TROOP SHIPS TO BE CONVERTED TO HOSPITAL SHIPS

Five more troop ships are being stripped of their armament and converted into United States Army hospital ships in order to insure speedier return of America's combat wounded.

The addition of these new ambulance type hospital ships will bring the number of hospital ships operated by the Army up to 29 with facilities for transporting more than 18,000 sick and wounded.

Conversion of the new ships, which, together, will be able to carry 5,355 patients, will be completed in about four months. They will be painted white with red crosses and green bands—which insures protection under the Geneva Treaty—and be ready for service by June or July.

The *Saturnia*, with a speed of 19 knots and gross tonnage of 24,470, will be the largest and fastest hospital ship afloat. A former Italian luxury liner, built at Trieste, Italy, in 1937, she is 630 feet long and will have a capacity of 1,300 litter and 388 ambulatory patients.

The other vessels slated for conversion are the former French liners *Columbie*, with a capacity of 608 litter and 172 ambulatory patients, and *Athos II*, which will carry 615 litter and 264 ambulatory cases; the former United States liner *Republic*, with a capacity of 900 litter and 300 ambulatory patients; and the *President Tyler*, with a capacity of 650 litter and 158 ambulatory patients.

Two other Army vessels now are under conversion as hospital ships. They are the *Ernestine Koranda*, named for an Army nurse, and *Louis A. Milne*, named for a former New York Port surgeon.

## Promotions, Office of The Surgeon General

Lieutenant Colonel to Colonel: Joseph Francis Sadusk, Jr., MC, of New Haven, U. S. Typhus Commission.

## Promotions — Changes of Station

Lieutenant Colonel Edward Augustine Abbey, AUS, New Haven, has been promoted to Colonel.

Lieutenant Colonel Ralph M. Tovell, Hartford, AUS, chief consultant in anesthesia for the European Theater of War, has been promoted to Colonel.

Alexander S. Rogawski, Waterbury, has been promoted to 1st Lieutenant and transferred from Camp Barkeley, Texas, to Veterans Administration Facility, Perry Point, Maryland.

Edward R. Smith, Lt. (j.g). USNR, Meriden, has been transferred to Main Dispensary, Norfolk Navy Yard, Portsmouth, Virginia.

Major William B. Koufman, AUS, Bridgeport, is chief of surgical service in one of the General Hospitals overseas.

Captain Joseph Becker, AUS, New London, has recently been transferred to Winter General Hospital at Topeka, Kansas, from Harmon General Hospital, Longview, Texas.

George Whiting Hebard, AUS, New Canaan, has been promoted from Major to Lieutenant Colonel.

R. H. Jordan, Capt., AUS, New Haven, has been promoted to Major and is commanding officer of a Station Hospital. He has been in India the past two years.

Irving S. Dichter, 1st Lieut., AUS, Stamford, has been promoted to Captain and is stationed at an Evacuation Hospital.

Captain R. A. Montano, AUS, Hartford, is now at the Station Hospital, Army Air Field in Tonopah, Nevada.

## War Medicine: Vol. 6, No. 6, December 1944

This issue of War Medicine contains only seven articles but all are interesting and contribute to scientific knowledge resulting from the present war. In "Experiences with Anesthesia in Combat Areas" Captain Irving R. Hayman, MC—AUS, describes the problems encountered by the anesthetist with a field ambulance unit in Africa and with a British general hospital in Sicily. His account is interesting and instructive. Colonel Samuel J. Kopetzky, MC—AUS, known to many Connecticut physicians, presents a study of the cases of 696 registrants with psychiatric diagnoses from the New York City Selective Service area. The study was made in an attempt to determine the psychiatric criteria for rejection for service. Colonel Kopetsky concludes that the Medical Survey Program used in New York City "provides, to a great extent, a better means for a more satisfactory selection of men who are mentally suited for the responsibilities of military service."

Acute high altitude anoxia is discussed by Captain Robert A. Kritzler, MC—AUS. Twenty-seven necropsies were performed on members of high altitude bomber crews in which death had been attributed to anoxia by the Air Force medical officers who had investigated the cases. Capillary congestion, except in the skeletal muscles, and the presence of fat-free, glycogen-free vacuoles chiefly in the myocardium and liver is described. Three physicians in Nashville, Tennessee, contribute an article on the treatment of staphylococcic and penumococcic meningitis with sulfathiazole and sulfadiazine. They observe that oral sulfadiazine is more beneficial than sulfathiazole in experimental staphylococcic meningitis and in experimental pneumococcic meningitis.

"The Marijuana Addict in the Army" by Captains Marcovitz and Myers, MC—AUS, presents the results of observation of 35 addicts at the Army Air Forces Regional Station Hospital at March Field, California. "Altered Taste in Dengue" by Captain Stephen R. Elek, MC—AUS, emphasizes the aid this symptom offers in differential diagnosis. An interesting report of the results of a study of preflight breathing of oxygen on abdominal gas pain resulting from decompression to 38,000 feet is submitted by a group at the Aero Medical Laboratory, University of California. Two hours of preoxygenation was found to cause a decided reduction in the incidence and severity of such pain from decompression.

Twenty-three pages of Abstracts from Current Literature, British and American, and seven book reviews complete the issue.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Lt. Comdr. F. P. Rogers, USNR, Hartford

U. S. Naval Hospital,
Bremerton, Wash.,
6 January 1945

Many thanks for your letter of some time ago inviting me to write a letter of activity and whereabouts for the JOURNAL. I'm sorry not to have gotten to it before. I've enjoyed tremendously the letters in past issues concerning the Hartford men. Hartford Hospital is well represented, pretty much over the face of the earth. The JOURNAL has arrived fairly regularly, much to my enjoyment. Your secretarial staff is to be congratulated on keeping up with the constant changes of addresses that is going on.

It doesn't seem 22 months ago that I left Hartford bound for Washington, D. C., commissioned in the Public Health Service. After a month's indoctrination in Bethesda, Md., I was sent to San Francisco for reassignment. From there I received orders to organize and operate a public health unit in the cantonment area of Central Oregon with headquarters at Bend. This town of normally ten thousand people situated on the high desert just east of the Cascade mountains is given over, in peace time, almost exclusively to the lumbering and manufacture of ponderosa pine.

In war time it found itself with an engineers' camp (Camp Abbot) and two Army Air fields (Madras and Redmond), all within 25 miles—and a 350 per cent increase in population. I was given a staff of 5 nurses, 2 secretaries and a sanitarian. Public Health problems were many and real, and

for several months I found myself completely absorbed in a program which contributed much, I think, to the well being of both the civilian and military personnel.

Aside from scarlet fever and meningococcic meningitis, which was endemic and mostly among the military, our most interesting epidemic was that of poliomyelitis, which numbered 28 cases, 25 of which were among civilians. This area had known no poliomyelitis in the past 17 years. Sixty-seven per cent of our cases were over 21 years in age with outside limits of 3 to 57 years. There were two deaths.

My resignation from the Public Health Service, and transfer into the Navy was accomplished, in due course, and after considerable rugged detail. My first tour of duty was at the U. S. Navy Hospital in Astoria, Oregon. As this hospital was not at that time, and has only recently been commissioned, I was loaned to the Naval Air Station at Astoria on the general medical staff. After less than a month, I received orders to the U. S. Naval Hospital at Bremerton, Washington, which is within the compound of the Puget Sound Navy Yard. I was sent here to replace the pediatrician who had received orders for sea duty.

I enjoyed Louis Middlebrook's letter in the JOURNAL particularly, for we are having similar experiences in Family Service for Navy dependents on opposite sides of the continent. Our personnel is entirely Navy, and while Louis has been learning pediatrics, I have been learning obstetrics. There are three of us on the family service, two obstetricians, and myself. Our clinics and wards are part of the Naval Hospital here. Our outpatient load is large, with an average of 2,000 visits per month. We maintain a 40 bed general medical and surgical floor, as well as 25 beds for Ob patients, 10 beds for pediatrics, and a 25 basinette nursery. We average 55 deliveries per month, and I take my regular watch every third day. Thank God the first one was a multip, for it helped a lot just to be able to stand there and catch. My last baby had been delivered in 1933 in Hartford Hospital. After 9 months of this I feel a bit more at home.

We do our own ob and gyn surgery and have one morning a week on the surgical schedule.

Patients pay $1.75 per day, be they dependents of apprentice seamen or admirals! Since we keep obstetrical patients 8 days, a baby costs $14, and in the case of males we throw in the circumcision. They can get their $14 from EMIC or Naval Relief. Most of them do.

Saw Bill Scoville in Portland, Ore., well over a year ago. Had Bob Hepburn on our staff for a couple of months. He came to us via the sick officers quarters, but he did a grand job pinch hitting in urology and dermatology, and was well liked by the staff. I have Miss Root (a H. H. nurse and formerly in the premature nursery) as my nursery nurse at present. She's doing an excellent job.

Edith and I were delighted to run into Lt. and Mrs. McGuire (Barbara Weld) at the Officers' Mess the other night. It was difficult to believe it was Barbara. We hope to see more of them.

The men here are getting orders fairly frequently. There are great things brewing in the Pacific. I have been getting my Bu Med Letter and JOURNAL readdressed to me from the USS— FPO San Francisco, for the past 5 weeks. I've either had orders to sea which have been cancelled, or they haven't caught up with me yet.

It's grand having the family with me, and except for a few months at a time, the Rogers have been pretty much of a family unit.

My regards to you all at home.

Fred

## From 1st Lt. Thomas Mirabile, AUS, East Hartford

Belgium,
January 6, 1945

Your nice letter finally caught up with me in the field here in Belgium, for which thanks very much.

* * * *

At the present writing I am on temporary duty as a replacement with an airborne unit at the front. I have been kept quite busy lately as a result of action which you will have read about in the papers by the time this letter reaches you. Working at an aid station is quite an experience. One has to work fast and in terms of evacuation rather than of curing, for which there is no time. The use of plasma is probably the best life-saving measure at the front.

I certainly miss the hospital and my general practice although I enjoy the thrills that come up now and then around here. Be sure to remember me to the staff.

* * * *

Tom

## From Lt. Col. George W. Hebard, AUS, New Canaan

7 January '45

Thank you for your letter of some time back, but recent arrival. I am glad to hear from the Connecticut Society, as that is the state for me, despite the fact my wife and boys have taken up quarters out west (New York) since I left. Since D+17, our outfit has been in France, for the most part travelling around with 3rd Army; my particular job is that of running the Ward Section of this 400 bed hospital. Our function is mostly surgical, but I'm keeping in touch with enough medicine, my own field, to keep from getting too rusty. We are all ready to come home any day, but it looks like there is plenty left for us to do before that happy time.

George W. Hebard

## From Lt. Col. Albert E. Herrmann, AUS, Waterbury

12 January 1944

It is not so very long ago that I received your letter, but with the change of APO's and the rapid movement of our unit since our arrival in the European Theater, it was delivered at a rather late date.

You probably know that I am the Commanding Officer of the —— Field Hospital, and that we have already seen service in the Pacific Theater. This hospital was part of the invasion force that landed on the island of Kiska. No resistance was met, so the need for hospitals was not as great as had been anticipated. In the next 7 months, the unit learned many things—not medical. I can assure you that every officer and man became proficient at keeping himself warm and dry. There was unanimity of opinion that after the "Sons of Heaven" had been beaten, that they should be forced to live in the bleak, foggy, desolate islands of the Aleutian chain.

Approximately 90 days after we left Kiska, we arrived in the United Kingdom, after having spent a short time in the States. Our first mission had to do with mounting the invasion. We were ready if the Nazis attempted to interfere with our forces embarking for the continent. One of my units was used elsewhere in the United Kingdom as a holding unit for air evacuation, and the first D-Day casualties that were sent back to the States, passed through the holding station operated by the "Fightin ——."

We were later sent to France and were quickly rushed to Brittany where we were urgently required to aid in the evacuation of wounded in the Brest campaign. Here we also evacuated many German prisoners of war. I had the opportunity to see the German military hospitals in Brest while they were still operated by their staffs. I can assure you that the American field hospitals were much cleaner than were the German hospitals at Brest immediately after surrender, but the personnel of the hospitals all showed the mental strain caused by the terrific fire power of the American artillery and had little of the Nazi spirit left. I later saw many of these medical officers furnishing medical care for their own men in Prisoner of War inclosures.

Another section of my unit furnished station hospital care in another area in Brittany, all under canvas, but service with a smile was the motto and apparently appreciated by our GI patients. Later we were rushed to Belgium where the need for hospitalization became acute in a certain area. Forty-eight hours after arrival in a good brick building, we were receiving all manner of patients.

If you have been left somewhat breathless in reading of the manner that we have been pushed from one theater of operation to another, and then to Scotland, England, Wales, France, and now in Belgium, you may appreciate the versatility, flexibility, and mobility of the —— Field Hospital. There is never a dull moment, and I can assure you that the Commanding Officer does not find time hanging heavy on his hands. The unit has operated in tents and in buildings, has operated holding units for air evacuation, sea evacuation, station hospitals, and general hospitals, and also helped mount the invasion. We can do more tricks with tents than a circus after the war.

To maintain efficiency of the unit in a high standard, I have the able assistance of some good Connecticut Yankees. Captain William M. Wiepert of Avon, executive officer; Captain Sebastian Garofalo of Middletown, dental officer; 1st Lt. Alma Martinkat of Naugatuck, assistant chief nurse; Tec. 3 Edward J. Musante of Bridgeport, surgical technician.

From all of this, you probably appreciate that I have little spare time, but when I do have time to think of the important things in life after the war is over, all my thoughts center in the quiet hills and woods of Connecticut. I have yet to see anywhere in the world a spot that can surpass it, and that is where I hope to be as soon as the big job is done.

Albert E. Herrmann

## From Major R. H. Kettle, AUS, Norwich

December 27, 1944

Thank you for your card of December 7. I am presently located in the Marianas. Thank you for mailing the JOURNALS. I was very sorry to learn of Dr. Bryan's death.

I am a Flight Surgeon attached to this Headquarters. The —— is very active these days. No doubt you have read of the raids on Tokio which are accomplished by this command. I will certainly be interested in reading the letters from overseas members of the State Society.

Ronald H. Kettle

## From Major A. B. Sundquist, Airborne Forces, AUS, Manchester

Belgium

2 February 1945

Thank you for the post card which arrived today. I am now somewhere in Belgium suffering from a mild form of home-sickness but otherwise in excellent health and spirits. I'm looking forward to the resumption of my practice in Manchester, Connecticut, but especially to getting back to the good life that Connecticut offers and to picking up old associations and old friendships. Your thoughtfulness for men in the service typifies the friendly attitude of the state as a whole and is much appreciated.

A. B. Sundquist

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## Captain Biondi Receives Medal

Word has been received that Captain Benedict Biondi of 120 Blatchley Avenue, New Haven, has been awarded the "Chinese Grand Star of Honor Medal for outstanding and distinguished service rendered by him to the Republic of China and to the Chinese Army." With the medal Dr. Biondi also received a certificate with the official Chinese signatures. Captain Biondi is now serving in China with the Fifty-third Portable Surgical Hospital.

## Dean Johnson Stresses College Training

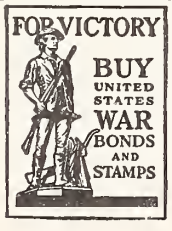
Dean Henry S. Johnson of the University of Connecticut College of Pharmacy and president-elect of The American Association of Colleges of Pharmacy was the speaker at a recent meeting in New Haven of the Connecticut Association for the Advancement of Professional Pharmacy. Dean Johnson stressed the importance to the public health of the present college training course which includes pharmacology, chemistry, pharmaceutical technique, biological sciences and basic training in languages. The Connecticut Association, the first organization of its kind in the country, is working indefatigably in the interests of better pharmaceutical standards in this State.

## Society Members Active in Connecticut T. B. Association

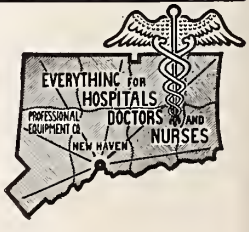
L. Rogers Morse, superintendent of Cedarcrest Sanatorium, has been appointed chairman of the Committee on Rehabilitation of the State Tuberculosis Association and David R. Lyman, superintendent of Gaylord Farm Sanatorium, chairman of the Committee on Budget. From the State Medical Society office, Grace Mooney has been selected as chairman of the Committee on Social Hygiene Information.

## Social Insurance Benefits in U. S. S. R.

The State budget for social insurance in 1944 provided for an expenditure of 433,500,000 rubles for aid to pregnant women and mothers and children. Maternity benefits were increased by 50 per cent, and the sum allotted for children's clubs, playgrounds, and exhibits of children's creative work was five times greater than the previous year.




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(SEE PAGE 2)

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*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
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*Windham County*, Andrew O. Laakso, Danielson



PUBLIC AFFAIRS

# A PLAN FOR THE MEDICAL INDIGENT

JAMES R. MILLER, M.D., *Hartford*

IT HAS been suggested in some quarters that organized medicine is without a program and while it is evident that "Social Planners" are not satisfied with the suggestions which have come from organized medicine, there is still a strong case in favor of building on what we have found to be reasonably satisfactory and at the same time experimenting with some of the newer techniques of providing medical care.

It is indeed doubtful whether the "Social Planners" will be satisfied with anything short of a revolution. Hayek in his recent book "The Road to Serfdom" has pointed out that "the question is no longer how we can make the best use of the spontaneous forces found in a free society. We have in effect undertaken to dispense with the forces which produced unforseen results and to replace the impersonal and anonymous mechanisms of the market by collective and 'conscious' direction of all social forces to deliberately chosen goals."

The arguments for the extension of government control over medical care may be considered under two headings: those concerned with preventive medicine and those concerned with curative medicine. But recognizing that the line between these cannot be sharply drawn, it can be stated that organized medicine believes in the development to the limit of their usefulness of methods of preventive medicine and is enthusiastically in favor of a National Department of Health. Provisions for such a department of health have been made in H. R. 1391 introduced into the present Congress by Representative Miller of Nebraska. In the field of curative medicine, however, there is a difference of opinion. The "Social Planners" have faith in the ability of government to direct and control a system of distributing the medical care while organized medicine doubts that a high quality of medical care can be maintained under this pattern.

There is a strong and natural desire to provide medical care for those who cannot afford to purchase it but the average citizen is apt to forget that society has already accepted the duty of providing the indigent with medical care along with food, clothing, and shelter. If the needs of this group are not adequately met, it is the fault of organized society and not of organized medicine, for the medical care of a large portion of it is already given without charge by the medical profession. It is precisely in this area that there is room for improvement in care as well as compensation.

It is not within the scope of this paper to propose a broad plan for the health of the nation. The suggestions which are here offered are concerned with the methods of providing care to the "medical indigents." These are defined as individuals who do not need public assistance to pay for the expenses of ordinary sickness but who are unable to meet the expense of major illness without great hardship.

Nicholas Murray Butler once remarked, "the man with a plan, however much we may dislike it, has a vast advantage over the group sauntering down the roadway of life complaining of the economic weather and wondering when the rain is going to stop."

## THE PLAN

1. That medical indigency should be defined by law.

*Presented at the Lions Club, Hartford, Connecticut, February 1, 1945*

2. That the costs of illness above a level to be determined should be met by tax funds in the case of medical indigents who meet the following requirements:

(a) The individual and his family should be covered by insurance against the costs of hospitalization and medical care in a manner and to a degree satisfactory to the administering state agency.

(b) The individual should present evidence that the costs of illness in any one year for his family have exceeded five per cent of the family income over and above the benefits received from insurance. The costs of illness should be calculated on the basis of hospital rates and of fee schedules which prevail in the insurance coverage.

3. Payment by the State should be made directly to the creditors and should protect the individual and his family from further obligation for these services.

4. Payments on behalf of the individual and his family should be made without prejudice but with the expectation of repayment. It is suggested that no interest should be charged if repayment is made within five years, thereafter a rate of interest to be determined should be charged and unpaid loans should be a preferred claim against the estate of the individual.

According to testimony given at the Pepper Committee hearings in September 1944 by Robert Lamb, representing the United Steel Workers, and based on a study of 1,000 steel worker families, it was found that in the group of families having an income of $2,000 to $3,000, 2 per cent of the families had outlays of more than $500 in a year and an additional 10 per cent had outlays of $200 to $500 in a year for medical services.

For the purposes of our consideration, even though it is a patent over-simplification of the problem, let us grant that the money laid out for medical services by these families was well spent and that it represented an answer to their medical needs. Let us further grant that the figures represent approximately the situation for the group of "medical indigents." If these assumptions have any validity, it would appear that the present types of insurance coverage for hospitalization, plus the rapidly expanding prepaid medical plans would take care of a large part of the needs of all but the two per cent of these families whose expenses ran in excess of $500 and perhaps one half of the next group who laid out $200 to $500.

Critics of the plan which I have suggested will immediately point out that conditions vary widely in various states not only in the prevalence of disease and the needs for medical care but also in the economic ability of the citizens to meet these needs. Local conditions will modify the plan.

It will also be objected that the plan is merely a subsidy and leaves totally out of consideration the need for improving the quality of medical care. This is granted. It wodld be well, however, to bear in mind what Simmons and Sinai once remarked, "No Health Insurance law has as yet been formulated primarily as a health measure, and it is doubtful if any are being administered with health care as a dominant purpose. All were enacted to meet the problem of poverty in time of sickness, and the treatment of disease has always been secondary to the relief of poverty. All systems are not insurance but subsidies."

Experience in underwriting insurance risks of many kinds has shown that minor losses are frequent but presumably can be borne without hardship by the insured. It is expensive to cover all small claims for in the aggregate they assume large proportions. Small claims also lend themselves to abuses not only by the claimant but on the part of the whole system which finds it more expedient to settle a claim on the basis of its nuisance value and to get rid of the claim lest the cost of administration become prohibitive. On the other hand, serious losses, even though they are individually large, are infrequent and are properly the field for the application of the insurance principle.

The present plan attempts to make use of three well known features of commercial insurance.

1. The "deductible clause" or the "waiting period."

2. The reinsurance of large risks.

3. The feature of co-insurance.

The "deductible clause" or the "waiting period" are devices which are used to eliminate small claims so that the premiums charged for coverage of serious losses can be kept at a low level. The analogy to reinsurance is self explanatory and the co-insurance feature recognizes the fact if the insured himself participates in some of the loss, he is more apt to guard against its occurrence.

Hospitalization insurance which is rapidly being extended to cover a large portion of the population falls short of its full capacity for social welfare in that it pays on small claims which could not possibly

be regarded as a back breaking burden for most of the insured. It has been calculated that a modest payment by all patients for the first week of hospitalization would enable the funds to insure limitless hospitalization for those who need it most. This, indeed, would be a great social service. The present pattern, however, is so firmly established that there is little hope of changing it and it may also be observed that any substantial payment for use would materially reduce the attractiveness of hospitalization insurance from the sales point of view.

If insurance plans are to be conducted on a sound financial basis, it is necessary to establish limits to the amounts that will be paid, for the insurance funds themselves are not limitless. The State is supposed to be the only possessor of a bottomless purse though it must not be forgotten that the depth of the public purse is limited by the willingness of the people to pay taxes.

The plan which I have suggested will not work unless a large portion of the "medical indigents" are covered by insurance. The purchase of such insurance should therefore be encouraged by government, labor, and industry and perhaps methods should be used to make such purchase easy for any who find it difficult. Ways should be found for covering individuals who are not engaged in large industrial enterprises. Farmers, storekeepers, domestic servants, and others should be covered in town or county groups provided certain percentages of the availables take the insurance.

Those who refuse to protect themselves against the minor costs of sickness by the relatively inexpensive insurance method can still pay their own way up to the specified 5 per cent of the family income that was suggested in the plan or if they have been unable to do this, they will be cared for by public assistance under the law as soon as their distress is great enough for them to qualify.

Some attempts to keep the individual off the public assistance rolls have been made by state hospitals for the insane and tuberculous, and by certain local welfare authorities, for government has an interest at this point. Expensive illness is one of the factors which force families to accept public assistance and if they can be kept on their own feet, much of the loan fund can be recovered. My suggestion is, therefore, to extend this practice and give it wider application.

This plan fits exactly into the requirements for an ordered service in medicine, so well stated by Lord Dawson of Penn, "I submit that such services must be something which suits the habits of thought of our people and should evolve from what already exists." And he points out "There are few callings in which there is so big a gap between routine and the best work as in medicine, and no profession needs to be so elastic in its government if it is to be dynamic, not static. . . . It is here that medical planning is up against the crucial difficulty, in that it requires collectivism for its fabric and individualism for human relationship. And individualism will not flourish easily within the rigid boundaries of a state service, but needs the freer atmosphere which belongs to the voluntary hospital tradition."

The suggested plan is given in its broadest outlines. It is admittedly incomplete. It does not answer many questions of administration and necessary changes in the law but it does present a thesis that the State should underwrite the excessive cost of illness by making use of available facilities in a manner which will tend to encourage the individual citizen to provide himself with health protection and as a co-insurer to assume some of the costs of illness for which he is often party responsible.

## Sensible Medical Plan

*From the Hartford Courant*

There has been so much huffing and puffing about socialized medicine by the pink-tinged New Dealers on the one hand, and the proponents of *status quo* on the other, that the sensible, progressive plan of socialized medicine proposed by Dr. James Raglan Miller in Hartford the other day is worthy of serious consideration. As Dr. Miller so aptly observed, there has been a deal of name calling on both sides, but a dearth of dispassionate study of the facts. To the arch-reactionary Dr. Miller recommended the fact that we already have socialized medicine to a certain degree in our medical care of the tuberculous, the blind, the mentally ill and the indigent. To the radical he pointed out the danger of shackling physicians with bureaucratic control.

The real question at issue is just how far the function of government may safely be extended. No system of medical care, socialized or otherwise, can be any better than the physician. It is he who improves medical care. Therefore Dr. Miller sees as the basic need an increase in the number and quality of physicians and facilities like hospitals, clinics, and diagnostic laboratories. Nothing on the record indicates that Government supervision or operation

of such facilities would contribute much if anything to their efficient operation. There is, indeed, evidence to the contrary.

The middle ground suggested by Dr. Miller would have the Federal, State and local governments underwrite the costs of prolonged and expensive medical care while encouraging its citizens to pay for less costly illnesses. Dr. Miller would have such assistance made available from the public treasury if these two conditions were met: a. The applicant must be covered by hospitalization and medical insurance. b. The medical expense must exceed 5 per cent of the annual family income. Payments would be made as loans without interest if they were repaid within five years.

While there may be some question about the feasibility of adopting such a program *in toto*, and about its adequacy, there is a great deal to be said for it because it eliminates bureaucratic control of the physician while at the same time providing some protection for the family of moderate means to whom serious illness might spell financial disaster. If further discussions of socialized medicine could be focused on this type of approach, the results would probably be far better than continued haggling between radicals and reactionaries, which thus far has tended largely to cloud the real points at issue.

## Bills Introduced Before the 1945 General Assembly

More than 2,000 bills and resolutions were introduced into the Connecticut General Assembly between January 3 and Friday, February 2, the last day for the introduction of legislation. There appears to be an unusual number of bills relating to public health and welfare. Some old familiar measures rejected in the past are back again and many new ones have been presented. The bill to create a permanent commission to provide care for the chronically sick is of particular interest as the next step in extending this desirable program.

BILLS INTRODUCED IN THE SENATE

S32—An Act Establishing a State Hospital for Inebriates.

This bill proposes to create a state hospital for the care of inebriates. No appropriation to finance the hospital is contained in the bill. (Committee on Public Welfare and Humane Institutions.)

S84—An Act Concerning the Charter of the Connecticut State Medical Society.

This bill provides for the participation of certain additional members of the Council of the Society as members of the House of Delegates. (Committee on Licensed Occupations.)

S113—An Act Concerning Examination for Venereal Disease of Persons Accused of Offenses Against Chastity.

Section 739g of the 1943 supplement to the general statutes is amended by this act to provide for payment by the State Department of Health of the costs of examination for venereal diseases ordered by the court in cases of persons accused of offenses against chastity and the recording of the results of such examinations with the State Department of Health. (Judiciary Committee.)

S114—An Act Concerning Reports of Conviction of Crime of Persons Practicing Midwifery.

Notice to the State Department of Health by the clerk of the court of all convictions of crime of persons practicing midwifery is herein provided. (Judiciary Committee.)

S121—An Act Concerning Actions for Injuries Resulting in Death.

The limit of recovery of damages in death cases is increased by this act to $25,000. (Judiciary Committee.)

S129—An Act Concerning the Use of Roentgen-Rays, X-rays and Radium.

This act would permit the use of Roentgen-rays, x-rays, or radium for therapeutic or cosmetic purposes only by licensed physicians, osteopaths or dentists. (Committee on Public Health and Safety.)

S130—An Act Concerning the Observation and Treatment of Germ Carriers.

Section 863e of the 1939 supplement is amended by this act to provide for state payment of costs of hospital care and medical treatment of *suspected* typhoid and paratyphoid carriers as well as for proved carriers as now authorized. (Committee on Public Health and Safety.)

S246—An Act to Require the Enrichment and Safeguarding of Bakery Products.

This act provides for the mandatory enrichment, on a uniform basis, of staple bakery products and regulates the sale of surplus and stale products. (Committee on Public Health and Safety.)

S249—An Act Concerning the Care of Crippled Children.

Under this act the terms "poor," "destitute" and "indigent" are eliminated from the statute pertaining to the care of crippled children. (Committee on Public Welfare and Humane Institutions.)

S279—An Act Concerning an Appropriation to the School of Nursing of the University of Connecticut for a Specialist to Teach Public Health Nursing.

An appropriation of $5,000 yearly for the next two years is provided to employ such a specialist. (Committee on Education.)

S288—An Act Concerning the Incorporation of Grace-New Haven Community and Authorizing its Consolidation with the General Hospital Society of Connecticut and with Grace Hospital Society.

This act provides for the combination under one management of all the property and activities of the Grace Hospital Society and the General (New Haven Hospital) Hospital Society. (Committee on Incorporations.)

S289—An Act Concerning Blanket Hospitalization, Medical and Surgical Insurance for Family Groups.

This act provides for the authority to write this type of insurance for family groups. (Committee on Insurance.)

S354—An Act Concerning Chiropractic.

Under this act, chiropractic doctors are permitted to prescribe hygienic and sanitary measures incident to the care of the body and to sign death certificates. (Judiciary Committee.)

S357—An Act Concerning Automobile Accident Relief.

This act proposes to establish a commission to administer auto accident relief and sets forth the duties of such commission. (Judiciary Committee.)

S383—An Act Concerning Chiropractic.

The inclusion of hygienic and sanitary measures in the definition of Chiropractic is provided by this act. (Committee on Public Health and Safety.)

S465—An Act Concerning Compulsory Liability Insurance.

This act provides for compulsory liability insurance on motor vehicles. (Committee on Motor Vehicles.)

S524—An Act Creating a Commission to Study the Subject of Health Insurance.

This act provides for the creation of a non partisan commission to investigate the subject of a system of health insurance for the people in this state. (Committee on Public Health and Safety.)

S525—An Act Concerning the Payment to State aided Hospitals for Care and Treatment Rendered to Beneficiaries Under the Terms of Chapter 99b.

This act provides for a rate which will more closely approximate the actual cost of such care and treatment to said hospitals and will raise said beneficiaries from the pauper level. (Committee on Public Health and Safety.)

S540, 541, 542, 544, 545 and 546.

This group of acts concerns adjustment to a more equable level of rates paid for various beneficiaries to hospitals receiving state aid. Separate bills have been entered to cover payments to hospitals for care of the aged, dependent children, etc. (Committee on Public Welfare and Humane Institutions.)

S713—An Act Amending Section 1018e of the Liquor Control Act.

This act makes provision for a fund to be used for the study, treatment and care of the inebriate. (Committee on Liquor Control.)

S718—An Act Amending Section 461f of the Liquor Control Act.

The increase of permit fees to provide for a fund for the study, treatment and care of the inebriate is proposed by this act. (Committee on Liquor Control.)

S754—An Act Concerning the Establishment and Administration of a System of Health Insurance.

A state-wide system of health insurance is provided by this act. (Committee on Public Health and Safety.)

S755—An Act Concerning Prevention of the Spread of Tuberculosis.

This act provides for the control and dentention of recalcitrant persons with tuberculosis in order to check the spread of the disease. (Committee on Public Health and Safety.)

S756—An Act Prohibiting the Sale of Unpasteurized Milk or Milk Products.

The prevention of the sale of unpasteurized milk or milk products to the consumer is proposed by this act. (Committee on Public Health and Safety.)

BILLS INTRODUCED IN THE HOUSE OF REPRESENTATIVES

H66—An Act Concerning Accident and Health.

This act enables citizens to purchase a so-called family expense policy under which not only the

insured but members of his family may be included. (Committee on Insurance.)

H144—An Act Creating a Commission on the Care and Treatment of Aged, Infirm and Chronically Ill People of the State.

This act creates a commission of five Connecticut residents, appointed by the governor, two of whom shall be the commissioner of health and the commissioner of welfare. This commission shall continue to study the problem of the care and treatment of the aged, infirm and chronically ill people of the state, shall plan and initiate a building program and shall have the authority to staff and operate the buildings constructed within the program. The sum of $1,000,000 is appropriated to initiate the program. (Committee on Public Welfare and Humane Institutions.)

H191—An Act Making an Appropriation for Buildings for the State Department of Public Health.

This act appropriates the sum of $989,500 to acquire a site and erect and equip a building to provide for quarters for the State Department of Health which will eliminate outside rentals. (Committee on Public Buildings and Grounds.)

H192—An Act Concerning Exemptions (Narcotic Drugs.)

This act proposes to amend Section 592d of the 1937 supplement to prohibit the sale of paregoric without prescription because it contains opium and is habit forming. (Committee on Public Health and Safety.)

H193—An Act Defining Narcotic Drugs.

Subsection 14 of Section 970c of the 1935 supplement to the general statutes is amended to include isonipecaine, by whatever trade name identified, as a narcotic drug. This drug is already included in the Harrison Act. (Committee on Public Health and Safety.)

H196—An Act Concerning District Departments of Health.

This amendment permits two or more towns, cities or boroughs to unite to form a district department of health; to form a district board of health, with representation based on population; the board to appoint a district health officer. Each participating municipality may receive up to $4,000 for any one year from the state and each district department of health may receive up to $20,000 for any one year. This combining of resources for the maintenance of health is on a voluntary basis. (Committee on Public Health and Safety.)

H256—An Act Establishing a Statewide Central Social Service Index.

The statewide social service index created by this act would make accessible in one central source information on state wards in the possession of all social service and welfare agencies. (Committee on Public Welfare and Humane Institutions.)

H317—An Act Concerning the Rights of Physicians to Prescribe for Their Patients.

This act provides for the permitting of physicians to prescribe methods or means for the temporary prevention of pregnancy when necessary to save life or prevent serious injury to health. (Committee on Public Health and Safety.)

H323—An Act Concerning the Transfer of Mentally Ill Convicts to Hospitals.

Under this act, the sheriff is empowered to choose a physician to examine mentally ill prisoners and is authorized to provide for payment of expenses of temporary hospitalization. (Committee on Public Welfare and Humane Institutions.)

H406—An Act Creating a Commission to Study the Problems of Alcoholism.

This act creates a five man commission which shall study the problem of alcoholism in this state. (Committee on Liquor Control.)

H440—An Act Creating a Social Protection Commission.

Provision is made for the appointment of the Commissioners of health, education, state police, public welfare, the chief justice of the supreme court of errors, the president of the board of directors of the State Farm for Women and three electors to constitute said commission, and its duties and powers are outlined. (Committee on Public Health and Safety.)

H451—An Act Creating a Board for the Examination of Mentally Ill Persons.

Provision is made for appointment by the governor of five persons to examine persons about to be committed to mental hospitals, one to be a psychiatrist, one a psychologist, one a medical man, one a surgeon, and one a psychiatric nurse or psychiatric social worker. Powers and duties of the commission are outlined.

H580—An Act Concerning the Definition of Mentally Ill Persons.

This act provides for defining the term mentally ill persons. (Committee on Judiciary.)

H593—An Act Concerning License to Practice Pharmacy.

Section 2825 of the general statutes is amended by this bill to extend the time from January 1, 1921 to January 1, 1934 during which working as an assistant to a licensed pharmacist qualifies an individual to take examinations for pharmacist license without graduating from a recognized school of pharmacy.

H601—An Act Concerning the Establishment and Administration of a System of Health Insurance and Making an Appropriation Thereof.

This act provides for a statewide system of compulsory health insurance to be financed by a one per cent assessment on the overall payrolls of employers and a matching one per cent contribution from the state. Benefits include medical, surgical and hospital costs and compensation for pay losses due to disability. A commissioner of health insurance, directed by a commission on health insurance, is the administrator. The state is districted, with local medical and finance managers, boards and advisory committees in each district. (Committee on Public Health and Safety.)

H602—An Act Establishing a State Plan for Mental Health.

This act provides for the establishment of psychiatric clinics at the state mental hospitals and training schools, expansion of the program of the bureau of mental hygiene and development of psychiatric services for children, to be partially financed by the state. (Committee on Public Health and Safety.)

H616—An Act to Provide for the Making of a Survey of All Hospital and Health Center Facilities in the State.

A complete survey of all the hospitals in the state is provided, in order to determine the need for additional hospital facilities. (Committee on Public Welfare and Humane Institutions.)

H617—An Act Providing for a State Hospital Survey.

This act provides for a survey of existing hospitals in order to evaluate the sufficiency of such hospitals. (Committee on Public Welfare and Humane Institutions.)

H811—An Act Concerning Insane Patients; Parole; Temporary Absence.

This act makes it possible for patients to remain on parole with relatives, etc., for one year instead of six months. (Committee on Public Welfare and Humane Institutions.)

H814—An Act Concerning the Establishment of a Joint Committee of the State Mental Hospitals.

Under this act, legal status is given to the informal joint committee of the three state hospitals. (Committee on Public Welfare and Humane Institutions.)

H847—An Act Concerning the Appointment, Meetings and Compensation of the State Board of Osteopathic Registration and Examination and Prescribing Additional Qualifications for Admission to the Practice of Osteopathy.

This act provides for compensation for members of the board of osteopathic registration and examination, increases the requirements for admission to examination for osteopathic licensure and gives to licensed practitioners of osteopathy the right to perform certain public health procedures. (Committee on Licensed Occupations.)

H999—An Act Empowering the Connecticut Hospital Service Incorporated to Contract with and Act as Agent for Medical Service Corporations.

This act provides that the Connecticut Hospital Service, Incorporated, may enter into contracts with and act as agent for medical service corporations. (Committee on Judiciary.)

H1000—An Act Concerning Natureopathic Physicians.

Natureopathic physicians are permitted under the provisions of this act to withdraw blood from patients for diagnostic purposes. (Committee on Judiciary.)

H1031—An Act Concerning Examining and Licensing Board and Commissions and Establishing a Department of Professional and Vocational Licensing.

The consolidation of twenty-one examining and licensing boards to form a department of licensure is provided by this act. (Committee on Licensed Occupations.)

H1059—An Act Requiring Milk Products in the State of Connecticut to be Pasteurized.

This act provides for the pasteurization of all milk or milk products sold in Connecticut. (Committee on Public Health and Safety.)

H1060—An Act Concerning the Sale of Milk and Cream Which Has Not Been Pasteurized.

The sale of unpasteurized milk is prohibited under this act. (Committee on Public Health and Safety.)

H1082—An Act Concerning Care and Segregation of Delinquents and Feeble Minded Persons.

Repeal of section 597e of the 1939 supplement to

the general statutes, which covers the commitment of defective delinquents and vicious feeble minded persons to the Connecticut Reformatory or the State Farm for Women is herein provided. (Committee on Public Welfare and Humane Institutions.)

H1109—An Act Concerning Maternity Care for Wives of Members of Armed Forces and Appropriation.

Twenty-five thousand dollars are appropriated to be expended in the provision of maternity care for wives of men in the armed forces. (Committee on Veterans Affairs.)

## The Crippled Children's Program Controversy

On November 17, 1944 over the signature of Frances Perkins, secretary of labor, the U. S. Children's Bureau issued the following regulation which is an amendment to Section 202.4, Services for Crippled Children: "Effective July 1, 1945 it shall be a condition of approval of a plan that it provide that diagnostic services will be made available thereunder to crippled children without restriction as to race, color, creed, economic status, legal residence, age, (except as to persons above the maximum age for which such services are legally availbale within the state), and the necessity of referral by any person other than the child's parents or legal guardian or similar restrictions inconsistent with the free availability of such services." This regulation has been withdrawn but because this policy may be revived a resume of the situation should be of interest.

The Children's Bureau has contended that the Connecticut 1943 plan requiring reference by a licensed physician of crippled children to diagnostic clinics placed an obstacle in the way of a crippled child who might be in need of diagnostic and treatment services and thus tends to defeat the purpose for which the State services were created. The Bureau even went so far as to read into the plan an implication that the family physician has a vested interest in the care and treatment of the crippled child, and that the parent of the child would not have the right to receive services which have been made available for him by the State of Connecticut.

This attitude on the part of the Children's Bureau has been clearly shown by the State Technical Medical Advisory Committee to have no basis. The Committee has made clear that crippled children may be admitted to the clinic for diagnostic services without the reference of a licensed physician although such a reference is expected and efforts are made to secure the same. The Committee has emphasized that it is important for the child's own physician to be in on all medical matters but do not deny the child diagnostic service. For further care reference by a physician is required. The determination of eligibility as far as economic status is concerned is done after the diagnostic survey.

The amendment to Section 202.4 quoted above was discussed at a meeting of the Crippled Children Technical Medical Advisory Committee which met at the office of the State Society on January 24, 1945. Those present were Dr. Paul P. Swett, Chairman, Drs. Robert Salinger, Edward Wakeman, Karl Phillips, Daniel Patterson, Creighton Barker, Howard Colwell, Chairman of the Public Health Committee of the State Medical Society, J. R. Miller, Chairman of the Council, and from the State Department of Health, Drs. Stanley H. Osborn, Martha L. Clifford and Louis Spekter. A change of the state program which would be necessary to comply with the directive of the Children's Bureau was considered to be of such far reaching consequences that the whole matter was referred to the Council of the State Medical Society with the request that recommendations be made to the Commissioner of Health, Stanley H. Osborn, in the name of the Society.

The Council took up the discussion at its meeting on January 25, and the Chairman of the Council was authorized to send the following letter to Commissioner Osborn.

January 26, 1945

Stanley H. Osborn, M.D.
Commissioner of Health
Connecticut State Department of Health
Hartford, Connecticut.

My dear Dr. Osborn:

At the request of the Crippled Children's Technical Advisory Committee, a sub committee of the Committee on Public Health of the State Medical Society, the Council has reviewed the directive of the Children's Bureau, United States Department of Labor, Section 202.4, dated November 17, 1944, and the Council now wishes to inform you of the policy which it has adopted on behalf of the Connecticut State Medical Society in regard to this directive.

Connecticut physicians commend the cooperative attitude which the Connecticut State Department of Health has shown over the years toward the medical profession and they have demonstrated their approval by generous and willing participation in the preventive medical activities which the Department has directed. The program for aid to crippled children, developed with the assistance of Federal grants-in-aid by the Crippled Children's Division of the State Bureau of Child Hygiene, has been an instance of this collaborative effort. In the evolution and expansion of this program, the Technical Advisory Committee from this Society has worked closely with the Crippled Children's Division, reviewing and approving the various policies adopted for its operation. Physicians working in the program are doing so under the assumption that they serve the medically indigent and that in the opinion of the family physician or other responsible agency the special services of the Crippled Children's clinics are required. If there were no such purpose these physicians would not continue in the service at the present scale of remuneration, if, indeed, they would consent to participate at all.

If the Crippled Children's program is to provide diagnostic services, and perhaps eventually therapeutic services, without consideration of the economic status of the patient, as is proposed in Section 202.4 of the Children's Bureau regulations, we believe that the cost to the State of Connecticut will increase and will soon exceed the Federal grant-in-aid which the State may now forego by non compliance with this directive. For these reasons, the Connecticut State Medical Society must surely oppose any policy which places no restrictions concerning economic status on the availability of services under this program.

The Connecticut State Medical Society concurs in the statements of the Connecticut State Department of Health in its letter to the Children's Bureau dated July 15, 1942: "In adopting the above policies we believe that instead of obstructing medical and nursing care we are improving it by insuring that incidental illnesses will be adequately cared for by having a local physician supervising the medical care of that child and by making a closer relationship between the local physicians and the public health nurse and the patient."

We strongly disagree with the statement in the Bureau's letter to the State Department of Health on July 9, 1942: "There is an implication in this policy (requiring permission of the local physician for follow-up public health nursing services) that the family physician has a vested interest in the care and treatment of the crippled child and that the parent of the child does not have the right to receive services which have been made available for him by the State of Connecticut. We believe that this policy is unsound and has been adopted more in the interest of the family physician than for the crippled child who is in need of these services."

This statement is, in our opinion, unfounded and without merit. It suggests to us that the United States Children's Bureau has as much interest in dominating every phase of medical care in this program by the power of the purse as it has in rendering aid to our crippled children in Connecticut. We are confident that the regulations under which the present program has operated for a number of years have not caused neglect nor distress to any crippled child.

We sincerely hope that the Children's Bureau will take the requisite steps to modify its regulations so that it will be possible for the present Crippled Children's program of the Connecticut State Department of Health to be continued with Federal aid. In the event that the Federal grant-in-aid is withdrawn from the Connecticut program, because of unwillingness to accept the provisions of Section 202.4, the Connecticut State Medical Society will continue to cooperate in every way with the State Department of Health in providing diagnostic and therapeutic services consistent with the high standards that the people of this State expect.

Sincerely yours,
James R. Miller, M.D.,
Chairman of the Council

It is probable that the firm stand taken by the State Medical Society and by the State Department of Health has in conjunction with the protests from other states been effective in bringing about this suspension of the regulation. Although the word "suspended" may remove the regulation from the program for the current fiscal year, the word has an ominous temporary connotation. The price of freedom is eternal vigilance.

## California First State With Prepaid Health Bill

On January 24, according to the *San Francisco Examiner*, Governor Warren's "Prepaid Health Service" bill was introduced into the California legislature. The bill proposes a system of compulsory health insurance. Individuals under the pro-

posed State system, the bill asserts, are entitled to "general practitioner services rendered by a physician or surgeon licensed in California, whenever such services are required by the standards of good medical practice for preventive, diagnostic, therapeutic or other medical treatment or care."

"These general services may be performed at the physician's office, or in a hospital or clinic," or anywhere else in California "in accordance with the standard of medical practice in the community in which the service is rendered."

In addition, the bill provides the following "basic services:"

Consultation and specialist services in addition to those of the general practitioner.

Laboratory and x-ray services.

Necessary hospitalization, excluding ambulance service, for not more than twenty-one days a year for each separate and distinct illness or injury.

Drugs, medicines and biologics, bandages, splints, and other supplies prescribed by the attending physician and surgeon. Drugs other than preventive biologics are not included except when used in course of treatment in a hospital.

Such general nursing service as is afforded by the hospital in which treatment is given, but not private or special nursing service.

Dental services "for the extraction of teeth, and for treatment of acute infections of the teeth, gums, alveolar processes and the bone adjacent thereto, or fractures of the jaw."

With the exception of these dental services and the "general practitioner" services first mentioned, all the other services "shall be furnished only upon the certificate of the general practitioner or specialist to whom the patient is referred." Presumably, dental fillings and bridges would not be included.

Basic services are to be furnished for not more than one year or any one illness or injury, and will be provided for "tuberculosis and mental infirmities or disorders" only up to the time of diagnosis of such conditions.

Allowance is made for amendment of these basic service provisions by a two-thirds vote of the eleven man authority which will administer the prepaid medical service system. The Governor may suspend the operation of any such rule or regulation in his own discretion. Except for modification of the basic services enumerated in the bill, the authority may adopt rules and regulations by mere majority vote of its members.

When the financial condition of the Health Service Fund warrants, the bill sanctions extension of service to provide one or more of the following: Increase of hospitalization period, additional drugs, additional medical or dental services, optometrical services.

Administration of the system will be in the hands of the California Health Service Authority, which will function with the Department of Public Health. One of the eleven members of the authority will be the State director of public health, and the Governor will appoint the other ten for four year terms. Salaries of the members will be $25 a day while attending meetings, plus their actual expenses. The Governor will designate the chairman.

The authority is to consist of three representatives of employers, including one employer of agricultural labor; three employee representatives, two from organized labor and one public employee; three licensed physicians, one of whom is experienced in hospital management, and one dentist.

Except for the collection of contributions from employers and employees, on the basis of 1½ per cent from each on salaries up to $4,000, all details will be administered by the authority. Collections will be handled by the Employment Stabilization Commission, which already collect unemployment insurance funds in California.

The authority's first duty will be to set up rules and regulations and fix fees to be paid for all health services furnished under the act. The authority need not make these charges uniform throughout the State.

Broad powers are given the authority in fields allied to health service. It may investigate hospitals, groups of registrants (banded together in various health services), employers and fraternal or charitable or other non profit health service organizations which may enter contractual relations with the State service.

The State treasury is pledged to assure the operation of the health service system until June, 1949. In a final section, the bill pledges the "faith and credit of the State," and adds:

"It is the intention and purpose of the legislature and Governor of this State that, in the event the funds herein provided are insufficient to accomplish this operation, such additional funds shall be provided as may be necessary, to the end that the health and safety of the people of the State be properly and adequately safeguarded."

Farm labor and domestics are not included by compulsion, but can come in on a voluntary basis. All members of a working man's family would receive benefits on the same basis as the employee.

# NEWS FROM WASHINGTON

## New Bills In 79th Congress

HR1 by Mr. Ludlow of Indiana. A Bill to Provide Disability Benefits for Honorably Discharged Veterans Under Certain Circumstances. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Provides that any inductee who shall make a statement at the time that he is inducted that he has a definite pathology, or if such pathology is discovered at the time he is examined and he is nevertheless inducted and later, after serving, such pathology shall develop into a disability and it becomes necessary to discharge him, the said ailment or disability shall be assumed to have been aggravated by service.

HR56 by Mr. Izac of California. A Bill to Amend Section 1001, title X, of the Social Security Act, to Include Needy Individuals Who Are Permanently Crippled. Referred to the Committee on Ways and Means.

*Comment:* Provides that the blind shall be considered permanently crippled in interpreting the Social Security Act and entitled to all the benefits given to a permanently crippled or disabled person.

HR103 by Mr. Voorhis of California. A Bill to Grant Permanent and Total Disability Ratings to Veterans Suffering from Severe Industrial Inadaptability as a Result of War Service. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Provides that where a disability suffered by a veteran while in service results in producing a severe industrial inadaptability, interfering with his being employed or with his following continuously any gainful occupation, that veteran shall be considered as permanently and totally disabled.

HR140 by Mr. Voorhis of California. A Bill to Amend the Social Security Act, and for Other Purposes. Referred to the Committee on Ways and Means.

*Comment:* Provides for the amendment of the Social Security Act so as to make each State its own authority in interpreting the phrases "needy individuals." The Federal Government shall not object to the interpretation of the State nor refuse to cooperate with the State's program by denying it its proportionate share of subsidy because of a difference in the interpretation of this and other phrases.

HR141 by Mr. Voorhis of California. A Bill to Amend the Social Security Act, and for Other Purposes. Referred to the Committee on Ways and Means.

*Comment:* Here Mr. Voorhis takes a position similar to the one in the preceding bill; that is, that the State shall be the sole authority in determining the interpretation of such phrases as "needy individuals who are blind" and "blind individuals who are needy." The Federal Government shall not object to paying its share of the subsidy to that State because of a difference of opinion.

HR151 by Mr. Voorhis of California. A Bill to Establish More Equitable Procedure Governing the Determination of Service Connection of Diseases or Injuries Alleged to Have Been Incurred in or Aggravated by Active Service in a War, Campaign, or Expedition. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Provides that the veteran who has a disability which can be traced to his period of service has the right to have that disability considered as due to or aggravated by such service in line of duty.

HR284 by Mr. Randolph of West Virginia. A Bill to Provide for Health Programs for Government Employees. Referred to the Committee on the Civil Service.

*Comment:* Provides medical facilities for all Federal employees. There is already established some facility of this kind for certain departments, but Mr. Randolph would like to see it extended to cover all Federal employees. The services are to be established only upon recommendation by the Civil Service Commission after consulting with the Public Health Service and are to be limited to: (1) Treatments of minor illnesses and dental conditions, except in cases of emergency; (2) Pre-employment and other examinations; (3) Referral of employees to private physicians and dentists; (4) Education and preventive programs relating to health, including alleviating of health hazards in the working environment.

HR395 by Mr. Dingell of Michigan. A Bill to Provide for Public Health Insurance. Referred to the Committe on Ways and Means.

*Comment:* This is the 1944 bill. Mr. Dingell announces that he is engaged in drafting some amendments to this bill which he will introduce later. No senate bill on the subject as yet has been introduced.

HR525 by Mrs. Norton of New Jersey. A Bill to Provide for Cooperation with State Agencies Administering Labor Laws in Establishing and Maintaining Safe and Proper Working Conditions in Industry and in the Preparation, Promulgation, and Enforcement of Regulations to Control Industrial Health Hazards. Referred to the Committee on Labor.

*Comment:* Provides for the authorization of the Department of Labor "to cooperate with State agencies administering labor laws in establishing and maintaining safe and proper working conditions in industry and in the preparation, promulgation and enforcement of regulations to control industrial health hazards." A sum of $5,000,000 is asked to finance the work. I am informed that in most States the working conditions in industries are a responsibility of the Health Department. Two states, however, New York and Massachusetts, have such jurisdiction a part of the function of the Department of Labor. Mrs. Norton carried a similar bill last year.

HR567 by Mr. Rankin of Mississippi. A Bill to Extend Eligibility for Compensation to the Widows and Children of World War Veterans Who Had Disabilities Caused or Aggravated by Examination, Hospitalization, or Medical Treatment. Referred to the Committee on World War Veterans' Legislation.

*Comment:* If the veteran was, at the time of his death, entitled to or in receipt of monetary benefits then his widow and children shall be eligible for compensation.

HR569 by Mr. Rankin of Mississippi. A Bill to Provide Compensation or Pension for the Widows and Children of Deceased Veterans of World War I or World War II Who Had Disabilities Caused or Aggravated by Examination, Hospitalization, or Medical Treatment. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Herein Mr. Rankin specifically states that if the veteran is a veteran of World War I or World War II and dies while entitled to or in receipt of monetary benefit his widow and children shall be eligible for benefits.

HR584 by Mrs. Rogers of Massachusetts. A Bill to Provide Permanent and Total Disability Rating in Active Pulmonary Tuberculosis Cases. Referred to the Committee on World War Veterans' Legislation.

*Comment:* The bill reads thus: "That notwithstanding any provision of law or Veterans Regulations, any World War ex-serviceman shown to have active pulmonary tuberculosis of compensable degree shall be deemed to be totally disabled for purposes of compensation when hospitalized."

HR1391 by Dr. Miller of Nebraska. A Bill to Establish a Department of National Health.

*Comment:* Mr. Miller stated this bill would obviate the reintroduction of his bill to transfer the Children's Bureau to U. S. Public Health.

HR1442 by Mr. Miller of Nebraska. A Bill to Grant Payments to Retirement Beneficiaries Under the Social Security Act for the Payment of Medical Care Under State Insurance Indemnity Health Plans.

HR610 by Mr. Tolan of California. A Bill to Amend Section 40 of the United States Employees' Compensation Act, as Amended. Referred to the Committee on Judiciary.

*Comment:* Provides for defining the term "physician" to include chiropractic practitioners; only in those states where chiropractors have been licensed. Further provides that chiropractic practitioners should have hospital facilities such as those enjoyed by physicians and osteopaths.

HR612 by Mr. Tolan of California. A Bill to Provide for Grants to the States for Needy Disabled Adults. Referred to the Committee on Ways and Means.

*Comment:* Provides for the amendment of Title X of the Social Security Act by inserting after the word "blind," wherever it occurs in such title, the words: "or physically disabled to such a degree that they are not capable of self support."

HR650 by Mr. Allen of Louisiana. A Bill to Provide the Same Privileges for Hospitalization and Domiciliary Care for Campaign and Expedition Veterans as are now Applicable to World War Veterans. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Provides that any person who served in the military or naval forces of the United States during a recognized campaign or expedition and who was honorably separated from such service shall be granted hospitalization and domiciliary care by the Veterans' Administration.

HR686 by Mr. Bloom of New York. A Bill Relating to the Labeling of Boric Acid for the Purposes of the Federal Food, Drug and Cosmetic Act.

Referred to the Committee on Interstate and Foreign Commerce.

*Comment:* Provides that boric acid, or any substance containing boric acid, or any other substance which is poisonous when used internally and which is similar in appearance to another drug which is for use internally, must be labeled "Warning—Poisonous If Used Internally."

HR710 by Mr. Dickstein of New York. A Bill Making it a Federal Offense to Alter the Inner Surface of the Hand for the Purpose of Preventing Identification by the Use of Fingerprints. Referred to the Committee on the Judiciary.

*Comment:* Provides for imposing a fine of not more than $5,000 or imprisonment for not more than five years for altering or attempting to alter any part of the inner surface of one's own or any other person's hand or hands for the purpose of preventing identification by the use of fingerprints.

HR713 by Mr. Dickstein of New York. A Bill for the Creation of Medical Academies. Referred to the Committee on Military Affairs.

*Comment:* Provides for the creation of one medical academy in each corps area in the United States, each to enroll a minimum of 295 students to be selected as follows: Each Representative and Senator from the area shall designate 5 principals and 10 alternates, any vacancies shall be filled by the Commanding General of the Army Corps; candidates shall be at least 20 and not over 25 years of age, shall be graduates of a college or a university or possess the qualifications for entrance into a medical school in the State in which they reside, must be citizens of the United States and of good moral character. Upon satisfactory completion of the course of study the candidates shall be commissioned in the Army, or in the Navy, or in the Public Health Service; they must continue in such service for at least ten years, unless it shall be certified that there is no further need for their services.

HR763 by Mr. Peterson of Georgia. A Bill to Amend Public Law 257, 76th Congress, Approved August 4, 1939, so as to Provide Pensions to Peacetime Veterans of the Regular Army, Navy, Marine Corps, and Coast Guard Suffering from Arrested Tuberculosis Contracted While in the Service. Referred to the Committee on Invalid Pensions.

*Comment:* Provides that a veteran contracting pulmonary tuberculosis in service and in line of duty during a peacetime enlistment, to whom service connection and pension is granted by reason of such, if the tuberculosis has become or does become an arrested case, shall be entitled to a pension of not less than $50 per month.

HR1284 by Mr. May of Kentucky. A Bill to Insure Medical Care for the Armed Forces. Referred to the Committee on Military Affairs.

*Comment:* Provides that every woman now registered in a nurse training school shall be subject to registration and selection for induction into land or naval forces upon her graduation.

HR1415 by Mr. Angell of Oregon. A Bill to Provide for the Education of all Types of Physically Handicapped Children, to Authorize an Appropriation of Money Therefor, and to Regulate Its Expenditure. Referred to the Committee on Education.

*Comment:* Provides for the appropriation of $11,580,000 for each fiscal year to be apportioned among the States whose plans are approved by the Commissioner of Education.

## Win the War Before Discussing Health Insurance

Washington is watching with great interest the developments in California, where Governor Warren is urging a system of Compulsory State Health Insurance. Also in New York, where the CIO has introduced a State Medical Care Bill.

It is predicted that Washington will be closely watching State results before jumping into Federalized Medicine.

Senator Vandenberg has introduced a resolution calling for a thorough study of the Social Security Act. The report to be submitted by October, 1945. This may mean that no Senate hearing or action will take place during the interval on legislation concerning Social Security.

Democratic leaders say that the subject of Health Insurance is not being discussed for the present. Manpower—war—foreign affairs, are too important for any interference by domestic post war problems. The President will give the signal when the proper time arrives, by a message to Congress on the subject.

Congressmen are very busy attending committee meetings. There is an air of genuine seriousness wherever you go. Congressmen from all sections of the United States have toured the battlefronts, have received a great deal of confidential information pertaining to the war's progress, appear to be closer to their constituents than in former sessions. Many have lost sons in battle.

## Children's Bureau Busy

REACHING INTO DENTAL CARE

Dental care for all children under a public health program has been proposed by Dr. Martha M. Eliot, associate chief of the Children's Bureau.

If care for all children cannot be provided at the beginning, she said, then a good basic program would be to take care of at least those in the six to twelve year old group.

"We can make a start in breaking the backlog of dental neglect," Dr. Eliot said, "by providing care for at least a segment of the child population and bringing those children to adulthood with their teeth in good condition. Forseeably, if we took good care of the school population, year after year, little more than maintenance dental care would in time be needed for the adult population. Caring for children first is the most economical and most sound method of reaching the ultimate goal of care for all."

COUNTRY-WIDE CHILD HEALTH PLAN

A country-wide plan for maternal and child health services for all the population, which would key in closely with the post war "health center" network recommended by the Pepper subcommittee on wartime health and education, was shown to be in process of formulation by a Children's Bureau announcement.

Dr. Martha Eliot, associate chief of the bureau, who has charge of far reaching maternal and child health programs, stated that seventy leading physicians and professional workers, meeting in Washington as an advisory committee to the Children's Bureau, had endorsed "a nationwide survey of personnel and facilities needed to assure health services to all mothers and children, which will be undertaken by the American Academy of Pediatrics, with the help of the Children's Bureau and the United States Public Health Service."

Chairmen of the advisory committee which endorsed the survey were Dr. Nicholson J. Eastman, professor of obstetrics at the School of Medicine, Johns Hopkins University, and Dr. Henry F. Helmholtz, chief of the pediatric department of the Mayo Clinic, Rochester, Minn.

The advisory committee on maternal child health set up as its aim "a long term program directed at lowering maternal and child mortality and morbidity to an irreducible minimum" and advocated "the delivery of all women in good hospitals under the care of competent physicians."

On family financing of medical services, the advisory committee warned against any one formula, and added:

"It may be provided for by district payment to the physician by or for the individual receiving the services, by the extension of voluntary insurance plans on a local level, by compulsory insurance plans (extension of Social Security), by direct taxation on local or State level, by Federal grants-in-aid from tax funds as a joint responsibility of local, State and Federal Government.

"The determining factor should be the situation existing at the local level and undoubtedly a combination of the various methods of financing may be needed in many places."

## Propose U. S. Health Centers

A proposal that health centers be set up in every community to combine preventive, diagnostic and curative care and operate as a part of an integrated system of local, district and metropolitan base hospitals, was made in an interim report by the Pepper subcommittee on wartime health and education.

This national "health center" system, advocated before the committee by the United States Public Health Service, would consist of four basic types of medical center facilities: The small neighborhood or community health center, the rural hospital, the district hospital and, finally, the large base hospital. The plan provides for constant exchange between these units of information, training, consultation service, personnel, and for referral of patients.

Federal grants in aid and a large post war hospital building program would be necessary to setting up such a system.

The committee advocated some form of group financing which would offer complete medical care, reasonable but not "cut rate" in cost and which would permit free choice of physicians, allow democratic participation in policy making and provide for continuous experimentation and improvement.

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. H. Bertram Lambert, Bridgeport
*Vice President*, Mrs. Creighton Barker, New Haven
*Secretary*, Mrs. Charles W. Goff, West Hartford
*Treasurer*, Mrs. Julian G. Ely, Lyme

## WOMAN'S AUXILIARY OF THE FAIRFIELD COUNTY MEDICAL ASSOCIATION WELCOMING ADDRESS

Don J. Knowlton, m.d., *Greenwich*

The Author. *President, Fairfield County Medical Association*

Thank you very much for asking me to give the welcoming address. The invitation first stated that it was desired an outline be given of "The ways a Woman's Auxiliary could be helpful and the services it could render under the guidance of the Medical Association." As a result of this request considerable material is here for your use.

The first Woman's Auxiliary of this kind was organized in Dallas, Texas, sometime before May, 1922. It was a county auxiliary and was organized by Mrs. J. O. McReynolds. Later Mrs. S. C. Red of Houston, Texas, president of this county organization, was instrumental in starting the national organization which was finally founded on May 26, 1922 in St. Louis, Missouri. The objectives of this national organization were stated to be "to extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement of health and education; to assist in entertainment at all medical conventions; to promote acquaintanceship among doctors' families so that closer fellowship may exist."

Other states to form Woman's Auxiliaries early were South Dakota, Maine, Montana and Minnesota. Today forty-three states have Woman's Auxiliaries.

Any such step as this is bound to stir up conversation, favorable and unfavorable. Voices have been heard to say: "Isn't it a wonderful thing," and "It should have been done long ago." But other voices have been quite as loud in unfavorable criticism: "No need of such a step," and "The woman's place is in the home. Let her watch over her husband's health and keep things going smoothly at home."

Let us analyze the situation. Why has there been an agitation for a Woman's Auxiliary here? And why is the step towards formation of these auxiliaries becoming more active? First and foremost, this type of volunteer organization is America's democratic response to a call for help.

In your case the call for help has come from the doctor because of the greater demand on his time and skill during these war years. These demands have come as a result of the reduction in the number of doctors at home and also because of an increase of work. Another reason is the burden placed on the medical profession by post war planning, such as in the care of veterans returning and reorganization of established activities which have become dormant during the war. In this your organization can take a very active part, and being in constant touch with your husbands you can act as their emissaries.

Still another reason is the success of this movement in other communities. It may not continue to spread rapidly as it has come to my notice that there is a certain resistance to this innovation.

Still a fourth reason is that organized medicine is being put under heavy pressure to arrange for better distribution of medical care. This needs much thought, time, and effort; the sifting of experimental attempts at prepayment hospital and medical plans, organizing and reorganizing such plans, trial and error. There are many other reasons possibly of equal importance and many of less importance.

All these extra burdens at this time, not only in the direct care of his patients but also the innumerable other trifles such as administrative duties, welfare duties, and today the special burdens that have naturally fallen to him, have compelled the doctor to call for help. How you will answer his call is up

to you. Your set-up will determine this, but that is the why of this movement in Fairfield County.

It is through concerted endeavor on your part and our part that each community can be served and the best solution to the various problems reached. The physician in his daily contacts sees a crying need here and the need of a change there. It may be only in his own community or perhaps it is more or less universal. He is overworked at the time and has no opportunity to report it to his own organizations. He does speak of it to his wife and she in turn brings it up at a local or a general meeting and the Auxiliary at least has a chance to study and possibly to correct or ameliorate the condition.

One of the criticisms contingent on forming this Auxiliary is that the wife should stay home and take care of her husband. There are two ways of looking at this. If she just plain stays home she may not be able to be as useful to him and his work as if she could rub elbows with others in the same boat, swap experiences, compare notes, and go back to her husband with helpful innovations that will relieve him of worries and make his work more effectual.

Not all doctors' households are the same. Some are almost entirely free from the atmosphere of medicine. These are the specialists and members of groups who have no office at home and most of whose clerical work is done through an office staff. From these doctors' households wives with administrative ability will form the organizing and administrative network on your Auxiliary. The other extreme is exemplified by the doctor's household where the only office is at the home and where the wife is the office girl, entire clerical staff, and home supervisor as well. She has no time to help you with administrative details and organizational work, but she must not make the mistake of feeling she has no part to play in this Auxiliary. Attending your meetings will be of tremendous help to her, and her intimate knowledge of her husband's problems will be of even greater value to you. In between these two extremes will be all degrees of variations. Each of you can picture your own type of medical unit and the degree and kind of part you can play in this effort.

Concerted effort in contradistinction to isolated effort is your watchword. Isolationism is no longer possible. It is our hope that all wives can be reached and these facts brought home to them.

To counteract another criticism it must be made plain to everyone that this movement is not for a group of society-bent, idle doctors' wives. It is not for bridge parties and such. On the contrary, it is a form of mobilization of serious minded women who are responding to a call for help from their husbands. The call has not been entirely in response to the greater effort due to the war; so we must be prepared for permanency and not have in our minds demobilization after the war, unless after trial the effort has been found of insufficient value.

It seems wise to stress that the greatest service the medical profession can give to mankind is education. More than half our effort is educational. We teach our patients how to get well when they are sick; how to keep from getting sick—prophylaxis. When their babies are born we try to teach the mothers measures that will produce healthy bodied, healthy minded adults to people the world and to make the world better after we are gone.

So as my closing word to you, let me ask you to include in all your various activities education as your main objective, stressing the teaching of the fundamental truths of life as exactly as we can determine them; the teaching of tolerance in its broadest sense as the most likely means of promoting peace; and the teaching of health measures as the most likely means of promoting happiness.

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## Fairfield County

A luncheon meeting for the purpose of forming a Woman's Auxiliary to the Fairfield County Medical Association was held in the Ballroom of the Stratfield Hotel, Bridgeport, on January 18, at 1:00 P. M., Mrs. James Douglas Gold presiding. 105 reservations were received.

After luncheon the meeting was called to order and Don J. Knowlton, president of the Fairfield County Medical Association, was introduced and delivered the address of welcome. Dr. Knowlton discussed what he thought the aims of a Woman's Auxiliary should comprise.

Mrs. H. Bertram Lambert, president, and Mrs. Creighton Barker, vice-president of the Woman's Auxiliary of the Connecticut State Medical Society, addressed the meeting on the principles and methods of organization of the State Auxiliary. Mrs. Luther Kice of Garden City, Long Island, who is a member of the Executive Committee of the National Woman's Auxiliary and National Legislative Chairman, was guest speaker and she discussed the aims and objectives of the Woman's Auxiliary from her

experience in the New York and Nassau County Auxiliaries.

Mrs. Gold read the letter from the Fairfield County Medical Association assuring its sponsorship of a Woman's Auxiliary and asked for a motion of organization. Mrs. Paul H. Brown of Stamford made a motion that we "form an organization to be known as the Woman's Auxiliary to the Fairfield County Medical Association." This motion was seconded and carried.

Thereupon Mrs. Creighton Barker took the chair to ask for the report of the nominating committee. Mrs. Charles H. Sprague, chairman of the nominating committee presented the slate as follows:

Mrs. James D. Gold, Bridgeport, president.
Mrs. Harold L. Amoss, Greenwich, vice-president.
Mrs. William A. Geer, Stratford, secretary.
Mrs. Allan M. Ross, Darien, treasurer.

It was moved and seconded that the slate be accepted and the secretary cast one ballot for the slate as read. The question of dues was brought up and Mrs. Leroy Haven moved that "the dues of the Woman's Auxiliary to the Fairfield County Medical Association be $1.00 annually and that the wives of doctors in service be exempt from payment of annual dues until their husbands resume private practice." This motion was seconded and carried. Mrs. Gold announced that the Fairfield County Medical Association had donated $75 to the treasury of the Woman's Auxiliary. The newly elected officers of the Auxiliary were presented to the members by Mrs. Gold, who asked for a rising vote of thanks to Dr. Knowlton and then the meeting was adjourned.

The Board of Directors of the State Woman's Auxiliary held a meeting on February 12, at the executive office of the State Medical Society in New Haven.

## Hartford County

The Board of Directors of the Woman's Auxiliary to the Hartford County Medical Association met on January 19 at the Hunt Memorial Building, Hartford. Reports of committee chairmen were heard, and tentative plans for the spring annual meeting were discussed. Mrs. Arthur B. Landry presided.

Mrs. Charles W. Goff, Secretary

## Philadelphia Session of A. M. A. Canceled

The Board of Trustees of the American Medical Association, after consideration of all factors involved, has officially announced the cancellation of the Ninety-Fifth Annual Session of the Association scheduled for Philadelphia June 18-22. This is the fourth time in the Association's history and the second time during the present war that an annual session has not been held. In 1861 the annual session was postponed for a year because of the outbreak of the war between the states. In 1862 it was again postponed for a year. The 1943 annual session scheduled to have been held in San Francisco was cancelled. Last year the session was held in Chicago. It is expected that a meeting of the House of Delegates will probably be held in 1945 in Chicago at a time to be announced later in the JOURNAL. The action this year is taken voluntarily in order to cooperate to the fullest possible extent with the request of the Office of Defense Transportation and in the interest of the nation's war effort.

## A Medical-Dental School for Washington State

The Washington State Medical and Dental Associations are backing efforts being made to establish a medical-dental school in that state. Washington is one of the largest commonwealths without such a school. A state law provides that such a school shall be "at the University of Washington exclusively." A legislative appropriation will be necessary to finance the initiation of the project and to provide funds for administration. In addition, the physicians and dentists are planning to conduct a concerted campaign for donations, contributions and endowments.




THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# OBITUARY

## John Alexander Clarke, M.D.
### 1871 - 1944

John A. Clarke was born in New York City and spent his youth there. He entered Bellevue Medical College, where he received his academic and hospital training, completing this study in 1898. After practising over a year in South Manchester, he came to Greenwich at the turn of the century and served the public in a private and civic capacity for over forty years. For twenty years he carried on the work of medical examiner and was the first physician to enroll in the health program of the public schools, which work he continued with interest until forced to retire because of ill health.

Long a member of the Greenwich Hospital Association, as well as local and State medical societies, Dr. Clarke also kept up his interest in many local societies and clubs, especially in those interested in the development of youth. He was well liked by all because of his quiet, reserved personality and sympathetic feeling towards those with whom he came in contact.

His death occurred on last Thanksgiving Day after a year's illness. He is survived by his wife, daughter and two grandchildren.

T. J. O'Donnell, M.D.

# CORRESPONDENCE

## Concerning Prescriptions for Heavy Cream

Dear Doctor:

Recently I added my signature to yours to obtain heavy cream for one of your patients. I did this in order that normal physician-patient relationships would not be disturbed, since your patient presented a prescription to be countersigned by the Health Officer, in order to obtain this cream.

However, my signature means that I merely know that you are a licensed physician, and not that I have confirmed the fact that this patient is in need of such butterfats.

I should like to take this opportunity to call your attention to the February 19, 1944 issue of the Journal of the American Medical Association, page 511, where this matter of the need for such butterfats is discussed. In this report the adopted resolution of the Sub-committee on Medical Food Requirements of the Committee on Drugs and Medical Supplies of the National Research Council stated that there were no medical indications for cream of 40 per cent butterfat, which could not be met by light cream of 19 per cent butterfat.

Furthermore, a check-up with all of the local hospitals reveals that no heavy cream has been prescribed for any hospital patient in over a year and that they have found that the light cream actually does meet all their requirements.

It would appear in the face of this evidence that only under extreme circumstances can we justify the furnishing of heavy cream.

How long this order will be in effect, I do not know, but I am sure that you and your patients will be glad to have this brought to you attention.

Sincerely yours,
H. A.

## Activity of United Medical Service, Inc., in Connecticut Explained

370 Lexington Aveune,
New York 17, N. Y.,
February 7, 1945

Creighton Barker, M.D.,
Executive Secretary,

Dear Dr. Barker:

I am quite surprised that there is any misunderstanding in Connecticut, since we very plainly stated our object was to facilitate services to those subscribers who are employed in New York and come into our contractual relation by virtue of their membership in an employed group here in the city. In other words, our first object was to provide for the commuters who work in New York City; our second object was to facilitate the care of vacationists and travelers from our city.

You can be quite assured that we have no desire to extend our activities to the writing of risks in your territory. We are very happy that your organizations are taking care of your own people and we desire only the most cordial cooperative relationship with all parties concerned in this field.

Very truly yours,
/s/ Frederic E. Elliott, M.D.,
Medical Director

# SPECIAL NOTICES

## PROMINENT SCIENTISTS SPEAK AT INSTITUTE OF LIVING

For the eleventh successive year, the Institute of Living is bringing to Hartford outstanding men in the fields of neurology, psychiatry and allied sciences for the annual post graduate series of Conference Talks. These were started on February 7 and continue each Wednesday evening, over a ten week period.

This year's speakers on the latest developments in education, shock therapy, heredity, psychoanalysis, epilepsy, legal psychiatry, psychological testing and the work of the Baruch Committee on Physical Medicine, will come from Chicago, Washington, New York and Boston. Dr. Harry C. Solomon, professor of neuropsychiatry, Harvard Medical School and medical director of the Boston Psychopathic Hosiptal, opened the series on February 7 with a talk on "The Future of Psychiatry."

Dr. Nolan D. C. Lewis, professor of psychiatry, Columbia University and director of the New York State Psychiatric Institute of New York City, addressed the meeting on February 14 on "Shock Therapy—Evidence for and Against Damage"

On February 21, Dr. Abraham Myerson, clinical professor of psychiatry, Harvard Medical School and director of research of the Boston State Hospital, spoke on "Constitution and Heredity."

"Hypnotism As a Method of Therapy" was the subject of the talk by Dr. Sandor Lorand, professor of psychoanalysis, New York Psychoanalytical Institute, New York City, on February 28.

Dr. Robert H. Felix, Assistant Surgeon General, U.S.P.-H.S., Washington, D. C., will speak on March 7; his subject, "The United States Public Health Service Attacks Mental Illness."

"The Curability of Epilepsy" will be the topic for March 14. The speaker will be Dr. H. Huston Merritt, professor of clinical neurology, Columbia University, and director of the neuropsychiatric service, Montefiore Hospital, New York City.

On March 21, "Practical and Flexible Psychoanalytical Techniques" will be the subject of an address by Dr. Franz Alexander, associate professor of psychiatry, University of Illinois Medical School; director of the Institute of Psychoanalysis and attending psychiatrist, Cook County Psychopathic Hospital, Chicago.

Dr. Winfred Overholser, professor of psychiatry, George Washington University School of Medicine and superintendent of St. Elizabeth's Hospital, Washington, D. C., will talk on "Psychiatry and the Law" on March 28.

"Physics and Technology in the Development of Physical Medicine" will be the title of an address on April 4, by Francis O. Schmitt, PH.D., professor of biology and head of the department of biology and biological engineering, Massachusetts Institute of Technology, and a member of the scientific advisory committee of the Baruch Committee on Physical Medicine.

The tenth and last of the series of Conference Talks for 1945 will be given April 11 by Carney Landis, PH.D., professor of psychology, Columbia University and principal research psychologist of the New York State Pychiatric Institute, New York City. His topic will be "New Developments in Psychological Tests."

## SUMMER SESSION IN ALCOHOL STUDY ARRANGED AT YALE

A third Summer session will be held by the Section of Alcohol Studies of the Laboratory of Applied Psysiology at Yale University starting next July 10, Professor Elvin M. Jellinek, director of the section, announces.

Purpose of the Summer session, established in 1943 as the first formal school of its kind in the nation, is to make the findings of scientific research available for application to the problems of alcohol in the community.

This year's session, concluding next August 3, will include daily seminars and lectures presented by 24 authorities in various fields relating to alcohol. Enrollment at the session will be limited to 150 students, who will be housed at the University; and applications for admission must be made by next April 1.

### Lecture Subjects

Lecturers in the course will be as follows: Dwight Anderson, director, public relations, Medical Society of the State of New York; Dr. Andras Angyal, research associate, psychopathology, laboratory of applied physiology, Yale University.

Selden D. Bacon, assistant professor of sociology, Yale University; the Rev. Roland H. Bainton, professor of ecclesiastical history, Yale University; Edward G. Baird, research associate, law, section on alcohol studies, laboratory of applied physiology, Yale University.

Robert Freed Bales, assistant sociologist, Section on Alcohol Studies, Laboratory of Applied Physiology, Yale University; Marjorie Devereaux, psychiatric social worker, Yale Plan Clinics; Edward B. Dunford, attorney at law, Washington, D. C.

Dr. Robert Fleming, instructor in psychiatry, Harvard University Medical School; Leon A. Greenberg, assistant professor, applied physiology, Yale University; Dr. Howard W. Haggard, director, Laboratory of Applied Physiology, Yale University.

Donald Horton, anthropologist; Professor E. M. Jellinek, director, Section on Alcohol Studies, Laboratory of Applied Physiology, Yale University; Natalie Joffee, anthropologist.

Benson Y. Landis, lecturer in economics, Section on Alcohol Stuides, Laboratory of Applied Physiology, Yale University and associate secretary, Department of Research and Education, Federal Council of Churches.

Dr. Giorgio Lolli, assistant professor, applied physiology, Yale University; Raymond G. McCarthy, field investigator, Yale Plan Clinics; Austin H. MacCormick, executive director, the Osborne Association.

The Rev. Francis J. McPeek, assistant director, Summer Course of Alcohol Studies, and executive director, Department of Social Welfare, Federation of Churches, Washington, D. C.; Benjamin Malzberg, director, Statistical Bureau, New York State Department of Mental Hygiene.

The Rev. Otis R. Rice, religious director, St. Luke's Hospital, New York; Anne Roe, research assistant, psychology, Section on Alcohol Studies, Laboratory of Applied Physiology, Yale University; Harry S. Warner, editor, the International Student; William G. Wilson, director, Alcoholics Anonymous.

## CLINCAL RESEARCH MEETING

### To be held at the New York Academy of Medicine 2 East 103 Street, New York City May 16, 1945

The New York Academy of Medicine will hold a meeting Wednesday evening, May 16, to provide a forum in which research workers of New York City and vicinity may present results of original research in clinical medicine.

This meeting is being arranged by the Committee on Medical Education of the Academy in view of the dearth of meetings of national medical societies before which research work has usually been presented.

Presentations will be limited to twelve minutes. A brief period of free discussion will follow each presentation. The publication of presentations is not a necessary condition but the Academy plans to publish in the *Bulletin*, abstracts of presentations if the author so desires. The fact that material has in substance or in part been presented elsewhere will not be regarded as a bar to presentation, provided that the work represents recent research.

The Committee extends an invitation to all research workers of Greater New York and neighboring cities within a radius of one hundred miles, to submit abstracts, not to exceed two hundred words in length, of proposed presentations to the Secretary of the Committee on Medical Education of the Academy, 2 East 103 Street, New York City 29, not later than April 5, 1945. A formal invitation to participate in this program will then be extended by the Committee to the authors of papers selected for presentation.

## THE NEW YORK INSTITUTE OF CLINICAL ORAL PATHOLOGY, INC.

An open meeting of the New York Institute of Clinical Oral Pathology will take place at the New York Academy of Medicine, 2 East 103rd Street, New York City, on Monday evening, April 30, 1945, at 8:15 P. M.

There will be a symposium entitled "A Survey of the Antibiotic Problem."

The following outstanding investigators will participate:

Daniel Laszlo, M.D., Mt. Sinai Hospital, New York, N. Y. "The Role of Biotics and Antibiotics in Chemotherapy."

Frank Lamont Meleney, M.D., associate professor of clinical surgery, College of Physicians and Surgeons, Columbia University and director of Laboratory of Surgical Bacteriological Research. "The Problem of Penicillin in Treatment of Mixed Infectious."

Leo Stern, D.D.S., Mt. Sinai Hospital, New York, N. Y. "The Treatment of Acute and Chronic Infections of the Jaws with Antibiotics."

Kenneth M. Kahn, Lt. Col. MC—AUS, chief of section for otolaryngology, Halloran General Hospital, Staten Island, New York. "The Relative Value of Antibiotics in the Treatment of Otolaryngic Diseases."

Louis I. Grossman, D.D.S., associate in oral medicine, and head of Root Therapy Clinic. "Evaluation of Antibiotic Agents for Root Canal Treatment."

Ludwig von Sallmann, M.D., Department of Ophthalmology of the College of Physicians and Surgeons, Columbia University, N. Y. "The Role of Iontophoresis in Ocular Therapy with Antibiotics."

Alvin E. Strock, senior assistant dental surgeon (R), U. S. Public Health Service Hospital, Manhattan Beach, Brooklyn, N. Y. "Treatment of Ulcerative Stomatitis (Vincent's Infection) with Penicillin."

For further information address all communications to the Executive Secretary, 101 East 79th Street, New York 21.

## AMERICAN COLLEGE OF SURGEONS DEFERS WAR SESSIONS

The American College of Surgeons has deferred for the time being its 1945 series of War Sessions, four of which were to have been held in February, according to an announcement by Dr. Irvin Abell, chairman of the Board of Regents. Dr. Abell states that plans had been completed for the February meetings because earlier indications were that sessions of a strictly educational nature, limited to relatively small local areas, would be sanctioned by the War Committee on Conventions, but it now develops that the transportation crisis is so acute that even this type of meeting should be omitted in order to help the war effort, and the College is glad to cooperate with the agencies responsible for the movement of military personnel and supplies.

The American College of Surgeons has voluntarily omitted its annual Clinical Congress ever since the United States entered the war, in order to aid the war effort by minimizing the demands upon transportation facilities. The War Sessions were devised as a wartime expedient to preserve the educational values in so far as possible with greatly lessened demands upon hotel and travel services.

The February meetings were to have been held in St. Louis on the 2nd, in Louisville on the 5th, in Milwaukee on the 7th, and in Cleveland on the 27th.

"Oh, she's OLD! Almost thirty!"





**At twenty,** thirty seems ancient.

At thirty, forty is distant middle age.

At forty, well, it'll be a long time before you're fifty.

The point is that ten years *ahead* always seems like a long time. Yet, actually it passes "before you know it" . . . and you find yourself face to face with problems, opportunities, needs, that once seemed very far in the future.

**This is a good thing** to remember today, when you buy War Bonds to speed the winning of the war.

In ten years—*only* ten years—those bonds will bring you back $4 for every $3 you put into them today.

Think of what that money may mean to you in 1955. An education for your children . . . a home . . . maybe even retirement to the place and the life of your heart's desire.

All this your War Bonds can mean to you . . . if you buy all you can today and hold them to maturity.

**It won't be long** till 1955. Not half as long as you think.

# OUR NEIGHBORS

## New York

Beginning February 1 the Medical Society of the State of New York established a Bureau of Medical Care Insurance at its office in New York City with Mr. George P. Farrell, formerly of Buffalo, as director. Mr. Farrell's duties will be the supervision of the establishment on a broad base of prepaid medical care insurance in New York State.

On January 11, as a contribution to the more vigorous prosecution of the war, the Council of the Medical Society of the State of New York, in response to the government's request for cooperation in lightening the load on the Nation's transportation system, canceled its annual meeting, scheduled to be held at Buffalo, New York, April 30-May 3. The meeting of the House of Delegates will be held, unless further government restrictions on travel are announced.

Walter P. Anderton, a practicing physician in New York City since 1913 and assistant professor of clinical medicine at Columbia University's College of Physicians and Surgeons, was appointed secretary of the Medical Society of the State of New York at a meeting of the Society's Council January 11. He succeeds the late Dr. Peter Irving.

Dr. Anderton is associate attending physician at Presbyterian Hospital, where he has served on the medical staff since 1915. He is also consulting physician at the French and Knickerbocker Hospitals, New York City, and the Newport, Rhode Island Hospital.

The new officer is a member of the American Medical Association, the Medical Society of the State of New York, and the Medical Society of the County of New York, of which he is a past president. He also served on the county society's committee on legislation and was secretary of the board of censors. He has served as a member of the House of Delegates of the American Medical Association and the House of Delegates of the Medical Society of the State of New York.

Active in many other professional societies, Dr. Anderton holds membership in the New York Gastroenterological Association, the National Tuberculosis Association, the American Heart Association, the Harvey Society, the Quiz Medical Association, of which he is a former president, and the Association of the Alumni of Bellevue Hospital. He is also a Fellow of the American College of Physicians and the New York Academy of Medicine, president of the Francis Asbury Fund, and a trustee of the New York Dispensary.

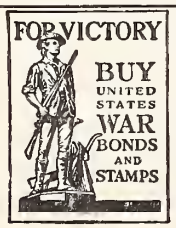
Dr. Anderton received his A.B. degree at Harvard College in 1908 and his M.D. at the College of Physicians and Surgeons of Columbia University in 1911. He interned at Bellevue Hospital and received his New York State Medical License in 1913.

Once again the medical profession of New York State is preparing to do battle against the "hardy January perennial," the Chiropractic Bill which was introduced into the State Legislature in January, 1945. The Bill is described in *New York Medicine* as "proliferating like a rank weed in a well kept garden, and threatening to deteriorate the high standards of medical education and practice in New York State."

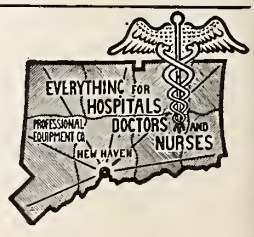
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## Phthalylsulfathiazole

According to *Professional News and Views*, phthalylsulfathiazole, one of the series of drugs which includes succinylsulfathiazole, is an intestinal antiseptic, being absorbed sparingly from the gastrointestinal tract and rapidly excreted in the urine. It has from two to four times the bacteriostatic activity of succinylsulfathiazole in the bowel. Orally administered, it does not cause any toxic symptoms, and, according to Poth and Ross, whose report on the drug was contained in the *Federal Proceedings of the American Society of Pharmacology and Experimental Therapy* (2:89(1934)) it has shown clinical effectiveness in the presence of a persistent watery diarrhea.




**PROFESSIONAL HEADACHES:** — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.

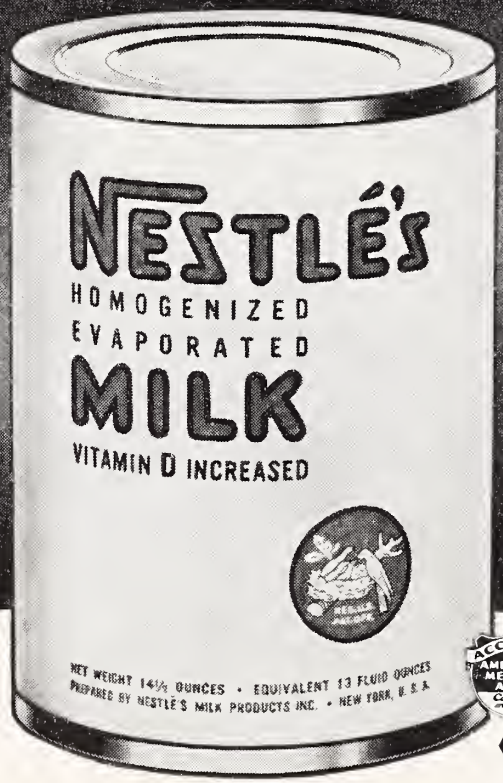



(SEE PAGE 2)

Today— NESTLÉ'S Lion Brand Milk has a NEW LABEL . . . and a great new value!




# 400 UNITS OF VITAMIN $D_3$*
# PER PINT




ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

WISCONSIN ALUMNI RESEARCH FOUNDATION Approved for VITAMIN D upon periodic tests

## UNDER THIS NEW LABEL
—this new, improved milk replaces NESTLÉ'S Lion Brand

Today—to meet a recognized need—Nestlé's has produced an improved evaporated milk with *greatly increased Vitamin D.*

*25 USP units of IRRADIATED 7-DEHYDROCHOLESTEROL have been added to each fluid ounce—so that this *new* Nestlé's Milk supplies 400 USP UNITS OF VITAMIN $D_3$ per reconstituted quart.

This improved product is now on grocers' shelves under the *new label* (shown above). The name Nestlé's on this label is, *as always,* your guarantee that there's no finer evaporated milk. *Fortification with Vitamin $D_3$ does not alter this milk's flavor or destroy any of its natural vitamins.*

So the extra advantages of NESTLÉ'S Evaporated Milk will be available to everyone—despite the increase in Vitamin D, there has been *no increase in price.*

No feeding instructions furnished to the laity.

**NESTLÉ'S MILK PRODUCTS, INC.**
**155 E. 44th St.— NEW YORK 17, NEW YORK**

# NEWS
## *from County Associations*

### Fairfield

The regular monthly meeting of The Bridgeport Medical Society was held on Tuesday evening, February 6, at the University Club in Bridgeport. The speaker was John S. Lockwood, associate professor of surgery at Yale University, and his subject was "The Use of Penicillin in Surgery."

### Hartford

The directors and executive committee of the Bristol Hospital were hosts to the medical and surgical staff at the Town Club in Bristol on January 17. After a very enjoyable dinner, the accomplishments of the hospital during 1944 were reviewed by Fuller F. Barnes and Frederick G. Hughes, and Ralph A. Richardson, president of the staff, expressed his appreciation for the manner in which the fellow physicians had cared for their patients in the absence of a resident physician and without interns. Several reels of war films were shown at the close of the program.

Carl L. Thenebe, a Hartford pediatrician, is the author of Life Overflows, "an original scrapbook arrangement of soothing philosophical thoughts" published by Bruce Humphries, Inc.

Hartford Hospital has been selected as the only hospital in the United States to be included in a training program in anesthesiology for Canadian Navy doctors. Ten Canadian physicians will be assigned to Hartford Hospital in rotation, each for two weeks training in anesthesiology under the department head, Curtis B. Hickox.

A group of Hartford physicians—Donald B. Wells, John C. Leonard, Ralph E. Kendall, Maurice T. Root—discussed "Lessons Learned in the Treatment of Burns from the Hartford Circus Disaster" at the mid winter meeting of the Rhode Island Medical Society. This was a joint meeting with the Providence Medical Association and was held at the Medical Library in Providence on February 5. A motion picture of the disaster was also shown and the program of the evening concluded with a discussion of "Practical Aspects of the Treatment of Shock" by Charles A. Janeway, Children's Hospital, Boston.

### Litchfield

Henry J. Kott, former practicing physician of Torrington, has returned after serving with the Medical Corps of the United States Army.

Louis Garston has reopened his office in Torrington after several months absence taking postgraduate work. His practice will be limited to diseases of the skin.

### New Haven

Lt. Col. Michael D'Amico, who has been in New Zealand for the past two and one half years, just recently returned to New Haven for a thirty day leave. He is to return to the Yale Unit as soon as his time is up which will be around February 19, 1945.

The most significant happening in New Haven has been the unanimous approval of the Grace Hospital and New Haven Hospital staffs to have a Grace-New Haven Community Hospital. This hospital is to be governed by a combination of the Board of Directors of the present New Haven and Grace Hospitals and a combination of the Chiefs of Staff of both the New Haven Hospital and Grace Hospitals. This is a great step forward and every doctor in New Haven is looking forward to the merger of these two outstanding hospitals in New Haven.

A few more members of the Yale Unit are on their way home from two and one half years in New Zealand, and will arrive within the next month.

Edward Lewicki and E. A. Post were recent visitors in Waterbury. Both are in military service.

C. H. Audet was installed as the new president of the Waterbury Medical Society at the January meeting.

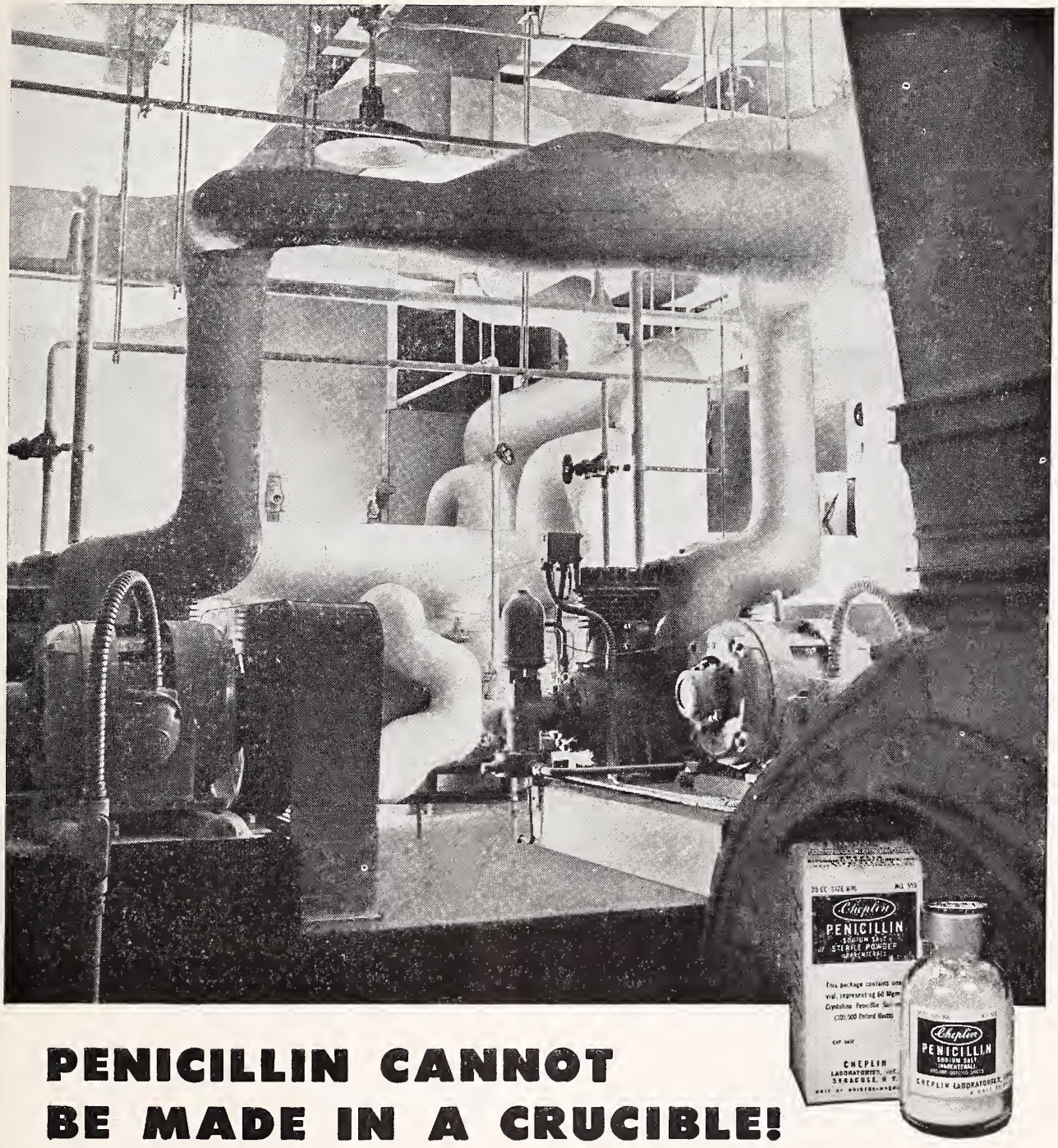
The February meeting of the Waterbury Medical Society was cancelled because of bad weather.

### New London

The annual meeting and banquet of the New London City Medical Society was held at the Mohican Hotel January 31, 1945. The following officers were elected for the ensuing year: President, C. Tyson Hewes; Vice-president, Edward Gipstein; Secretary, Treasurer, Lewis DeAngelis.

General business was discussed.

Daniel Sullivan, emeritus chief surgeon at Lawrence Memorial Hospital, New London, was requested by the chair to address the Society in March




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on "Modern Trends in Medical Practice." Many years of an active successful medical practice beginning as a general practitioner and later as a very successful specialist in general surgery has given Dr. Sullivan a great acquaintance with the trends in the practice of medicine.

The following valuable additions to the resident staff of the Lawrence Memorial Hospital in New London were made recently:

In charge of x-ray department, Edward Marcotte, McGill University Medical School, 1924. Associate in x-ray, Lahey Clinic, 1941-1943. Associate in x-ray, Massachusetts Memorial Hospital, 1943-1944.

In charge of laboratories and pathological department, Cornelius Mezey, graduate of University of Sorbonne Medical School. University of Budapest, Master in Pathology. Associate at the Pasteur Institute in Paris. He came to this country in 1927 as a fellow at Trudeau Foundation. U. S. Army, Chief of Laboratories, 1943.

The following internes were recently appointed:

Robert Beaudette, University of Vermont Medical School, 1944. Medical intern.

Allston Morris, New York University Medical School, 1944. Medical intern.

William Perkins, Harvard Medical School, 1944. Obstetrical intern.

The intern service at the Lawrence Memorial Hospital is rotating.

The trustees of the Norwich State Hospital appointed Dr. Riley H. Guthrie superintendent on January 1, 1945 and he assumed his new duties on February 1, 1945. For the past six years Dr. Guthrie has been first assistant physician of St. Elizabeth's Hospital, Washington, D. C., where he was also professor of clinical psychiatry at Georgetown University, School of Medicine. Formerly he had been chief executive officer, Boston Psychopathic Hospital; assistant to the commissioner, Massachusetts Department of Mental Diseases; and assistant superintendent of the Monson State Hospital, Palmer, Massachusetts.

Dr. Guthrie is a diplomate of the American Board of Psychiatry and Neurology; a member of the Massachusetts Medical Society, The Medical Society of the District of Columbia, The American Medical Association, The American Psychiatric Association, New England Society of Psychiatry, Massachusetts Psychiatric Association, American Psychopathological Association, and The International League Against Epilepsy. New London County Medical Association welcomes Dr. Guthrie and trusts he will soon be one of us.

The coming March meeting of the New London Medical Association will be addressed by Frank R. Pemberton of Boston. His subject will be "The Problem of Ovarian Tumors." It promises to be a most interesting meeting and anyone in the vicinity of the Uncas-on-the-Thames, Norwich, will be most welcomed. The meeting will be held in the Surgical Ampitheatre at 8:30 P. M.

It is to be noted that there will be NO annual meeting of the Connecticut State Medical Society this year, following the lead, no doubt, of the American Medical Association. This move is most praiseworthy and is simply another indication that the medical profession, as a whole, is doing all possible to assist in the war effort. New London County adds its approval to this move.

## News from Yale University School of Medicine

Col. Gillespie, R.A.F. Medical Corps, Liaison Officer between the American and British Medical Corps, gave an address on War Surgery in the Farnam Auditorium on January 12.

J. B. Amberson, professor of medicine at the College of Physicians and Surgeons of Columbia University, spoke on "Fundamental Concepts in the Diagnosis and Treatment of Tuberculosis" in the Brady Auditorium on January 31. The lecture was under the auspices of the Phi Delta Epsilon fraternity.

Franc D. Ingraham, assistant professor of surgery at the Harvard Medical School, addressed the Yale Medical Society on "Subdural Hematoma in Infancy" on Wednesday evening, February 14, in the Brady Auditorium.



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# NEW BOOKS IN REVIEW

*ENDOCRINOLOGY OF WOMAN. By E. C. Hamblen,* B.S., M.D., F.A.C.S., Clinical Professor of Endocrinology and Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine; Chief of the Endocrine Division and Endocrinologist, Duke Hospital, Durham, North Carolina. *Springfield, Ill.: Charles C. Thomas.* 1945. 571 pp. $8.00.

Reviewed by Stanley B. Weld

In 1939 Dr. Hamblen published *Endocrine Gynecology*, the most complete book of its kind to appear in the United States up to that time. Instead of publishing a second edition of that volume at this time, the author decided to rewrite the entire work, changing the title to *Endocrinology of Woman.* The arrangement of the new volume is different, being divided into five parts devoted to the endocrine glands, applied endocrine physiology, endocrine diagnostic methods, functional disorders of the endocrine glands and endocrinology applied to gynecologic disease. Two types of references are used in the new volume: (1) footnotes for documentation and amplification, and (2) lists of references for supplemental reading appearing at the end of chapters.

All that was said in the review of Dr. Hamblen's first volume on endocrine gynecology (Connecticut State Medical Journal, February, 1940) emphasizing its value and importance may be repeated for the newer volume. The author is painstaking and thorough and his contribution to this complex and difficult field is almost without equal in the United States. Many of the foremost endocrinologists disagree on methods of therapy. Dr. Hamblen comes out very strongly against the use of androgenic therapy in the treatment of the female. He does advocate repeated uterine injections with iodized oil to overcome tubal occlusion. He also describes two therapeutic schedules which are practical, effective and conservative: (1) a cyclic estrogen-progestin schedule for functional uterine hemorrhage, and (2) a cyclic one-two gonadotropin schedule for ovarian sterility.

The volume is well illustrated with charts, diagrams, black and white and colored photographs. Prepared under trying circumstances in these days of war, Dr. Hamblen deserves particular credit for attention to detail in every page of his book. The publisher is to be commended for the technical excellency of the finished product.

*TECHNIQUE OF THE STANDARD KAHN TEST AND OF SPECIAL KAHN PROCEDURES. By Reuben L. Kahn,* Chief of Clinical Laboratories, University of Michigan Hospital, Ann Arbor, Mich. *Ann Arbor: University of Michigan Press.* 1944. 52 pp. 25 cents.

Reviewed by Earle K. Borman

When the author of a widely accepted test for syphilis publishes his latest technique, he affects the practice of medicine. Nevertheless, this booklet will be found of interest only to those of the medical profession who have a first-hand interest in laboratory technique.

For the entire staff of the laboratory which performs Kahn tests, this booklet is on the "must have" list. Doctor Kahn has revised the previous (1942) edition. That is tantamount to saying that he has revised the techniques described.

In large part, this edition is a streamlined presentation of the essential technical details discussed more elaborately in his book, "The Kahn Test—A Practical Guide" (*Williams and Wilkins Co.*, Baltimore, Md.) but it goes beyond that in presenting changes and ideas resulting from the author's more recent studies. The size, format and manner of presentation are excellent for handy, everyday reference at the laboratory bench.

The serologist performing the Standard Kahn Test will find little change in this technique although one or two minor points are clarified. However, many laboratory workers will be pleased to find in an appendix what was conspicuously absent from the previous issue, a description of the preparation and standardization of Kahn antigen.

The greatest departure from the previous issue lies in the description of "Special Kahn Procedures." No change has been made in the technique of the "Presumptive Test" but helpful notes have been added. The technique of performing the "Quantitative Test" has been revised radically. The recommended procedure for the "Microflocculation Test" has been simplified and the description of it amplified. Finally, the "Verification Test" is briefly but completely outlined and its applications discussed. Fortunately, the author has exercised commendable restraint in discussing this test which is nowhere presented as more than an "aid" in differentiating between syphilitic and false reactions.

The practicing physician may not use this booklet, or even read it, unless he has a special interest in the performance of the Kahn test but its existence should cause him to ask the head of the laboratory which serves him if this latest issue is being followed. Laboratory heads would do everyone a good service by "cribbing" the remarks on prevention of hemolysis and broadcasting them to physicians who patronize their laboratories.

*THE PSYCHIATRIC NOVELS OF OLIVER WENDELL HOLMES: ABRIDGMENT, INTRODUCTION AND ANNOTATIONS. By Clarence P. Oberndorf,* M.D., Clinical Professor of Psychiatry, Columbia University. *New York: Columbia University Press.* 1944. 268 pp. $3.00.

Reviewed by Stanley B. Weld

Whether or not one wishes one's psychiatry presented by the canned method, one must admit that the author of this abridged edition of "Elsie Venner," "The Guardian Angel," and "A Mortal Antipathy" has done an excellent job for the student of psychiatry. For the casual reader so much has been deleted and so little left to the imagination with the author's extensive annotations that, as has been rightly said, the process results in a somewhat distorted presentation of the novels. The gain is achieved by disclosing the psychological originality and psychiatric insight of Dr. Holmes, characteristics undoubtedly overlooked for the most part in the latter half of the nineteenth century. Added to this the fact that the author has discovered a cer-

tain projected, far sighted expression of midern psychiatric thought in many of the passages quoted, we find ample reason for the plethora of comments which run along with the original text. These comments at times detract, at other times embellish.

The author's introduction is excellent. It pictures Holmes in his Calvinistic religious home background, explains the versatility of the man, and draws interesting parallels between Holmes and Freud. Freud is frequently referred to in the annotations. Holmes is described as a clinical psychiatrist, unappreciated as such by his contemporaries.

Each of the three "medicated novels" deals with a different type of mental disease, according to Dr. Oberndorf. "Elsie Venner" is a story of schizophrenia, "The Guardian Angel" of hysteria in a young girl, and "A Mortal Antipathy" of gynophobia in a young man. The volume contains bibliographical references and an index to the introduction and notes.

*MEDICAL USES OF SOAP: A SYMPOSIUM. Edited by Morris Fishbein*, M.D., Editor of *The Journal of the American Medical Association. Philadelphia: J. B. Lippincott Company.* 1945. 182 pp. 41 illustrations. $3.00.

Reviewed by STANLEY B. WELD

It may seem a bit fantastic to find a book devoted to a collection of articles on the medical uses of soap. Dr. Fishbein has made a real contribution in this volume, however, by arranging in one publication so much authentic information about a subject which has developed into one of this country's largest industries. Particularly the chapters dealing with soap in industry and soap for shaving may contain many surprises for the reader. The use of water and the soapless detergents adds to the interest and value of the book.

Dr. Fishbein closes the volume with a short chapter on "The Medical Uses of Soap." This is a very limited account of specific uses for soap, as in first aid, in venereal disease, and in scabies. It belies the title of the book as a whole which would probably much better have been just plain "Soap."

Some of the chapters close with bibliographies. The illustrations are good. The volume is well bound and should interest many physicians.

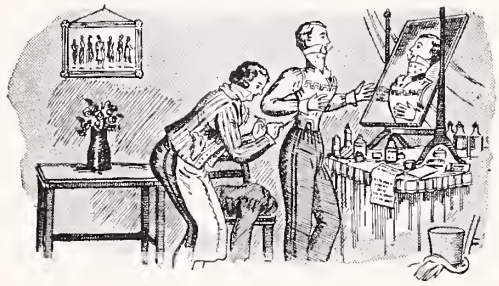
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## Northwest Medicine Official Publication for Alaska

Beginning with the January 1945 issue, *Northwest Medicine* will be the official publication of the Alaska Territorial Medical Association. Thus Alaska joins with Washington, Oregon and Idaho in utilizing the columns of a single medical journal. Editor Clarence A. Smith is to be congratulated in acquiring another child for his family circle. Alaska is fortunate. We shall expect to hear more from Ernie Pyle's "mosquito capital of the world."


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The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. IX APRIL, 1945 No. 4

# VENOUS THROMBOSIS AND PULMONARY EMBOLISM
## Review of 202 Patients Treated by Femoral Vein Interruption

ROBERT R. LINTON, M.D., *Boston*

INTRAVASCULAR THROMBOSIS, involving the veins of the lower extremity, is a pathological condition which is a serious threat to a patient's life. Death from pulmonary embolism is still one of the dreaded consequences of surgical operations, trauma of the lower extremities, serious illnesses and pregnancy. In recent years a better understanding of the relationship between venous thrombosis and pulmonary embolism has been established. In the past the treatment of thrombophlebitis of the lower extremity has been for the most part conservative. The patients have been treated by rest in bed, the application of heat in the form of warm, moist packs, and more recently the paravertebral novocain injection of the sympathetic lumbar ganglia, as advised by Ochsner and DeBakey.[1] These methods of treatment are time consuming and afford no safeguard against pulmonary embolism. Since Homans[5] first demonstrated that interruption of the femoral vein at the groin was a safe procedure and that it prevented pulmonary embolism, we have been interested in treating our cases of thrombophlebitis by this operation.

It has been pointed out by Ochsner and DeBakey[2] that there may be two types of venous thrombosis—thrombophlebitis and phlebothrombosis. The danger of pulmonary embolism in either of these two types remains a definite possibility despite the fact that clotting in thrombophlebitis is considered to result from injury to the vascular endothelium, from trauma, bacterial invasion or chemical injury, resulting in definite adherence of the thrombus to the vein wall so that it is unlikely to become detached. In phlebothrombosis the thrombus results from venous stasis and alterations in the constituents of the blood which increase the coagulability of it. Thus the clot may not be attached to the vein except at its point of origin, so that it may more readily become detached and produce embolism. It is our belief that from a therapeutic point of view it is unnecessary to differentiate between these two forms of venous thrombosis, since fatal pulmonary embolism may occur from either.

The ligation of a major vein proximal to an area of thrombophlebitis is not a new form of therapy. Hunter[3] in 1784 recommended compression of a vein above the thrombus in order to produce adhesive occlusion of the vessel above the area of phlebitis. Lee[4] in 1864 apparently performed the first operation. Since then numerous reports have appeared in the surgical literature on ligation or excision of the iliac and pelvic veins for postpartum septic thrombophlebitis. During the past five years proximal ligation has been advocated and performed by a number of authorities for the prevention of pulmonary embolism, secondary to deep venous thrombosis without sepsis. Homans[5] deserves much credit in drawing our attention to this form of therapy in cases of noninfected thrombosis of the deep veins of the lower leg causing pulmonary embolism. He successfully divided the superficial femoral vein in the groin of a patient in 1929. To Allen[6] at the Massachusetts General Hospital should go the credit for demonstrating the efficacy of this form of treatment in our clinic when thrombosis has involved the femoral

*From the Surgical Dept., Massachusetts General Hospital, Boston, Mass.*
*Read before the Hartford County Medical Association April 4, 1944*

and sometimes the iliac veins. He showed the feasibility of thrombectomy by suction through a large glass cannula inserted into the vein. By this means it is possible to remove the clot which may lie proximal and distal to the point of ligation of the femoral vein. Since Homans' article in 1934,[5] bringing our attention to the feasibility of interrupting the deep veins of the leg to prevent pulmonary embolism, this method of treatment has been advocated by a number of other authors. Kulenkampf[7] and Frund[8] in Germany, and Homans,[9] Bancroft,[10] Taylor,[11] Sears,[12] Welch and Faxon[13] and Allen[6,17] in this country, have reported excellent results in the prevention of embolism. The treatment of thrombophlebitis by lumbar sympathetic block, first advocated by Leriche and Kunlin[14] and popularized by Ochsner and DeBakey, may give symptomatic relief, but it does not protect the patient from the danger of pulmonary embolism. The use of anticoagulants, heparin and dicoumarol, in our hands has not prevented fatal pulmonary embolism. It is our experience that the patients usually do not have any pulmonary emboli during the administration of the anticoagulant, but soon after the drug is discontinued fatal and nonfatal embolism has occurred. For this reason it is our belief that these methods of treatment are not satisfactory.

It is a well established fact that most pulmonary emboli arise from thrombosis of the leg veins. Hampton and Castleman[15] have described the roentgenologic picture of pulmonary infarction, so that the diagnosis is much more frequently made than in the past. They further showed that 95 per cent of all pulmonary emboli, exclusive of heart origin, can be traced to the leg veins. Careful postmortem examinations have showed that the thromboses start in the veins of the calf muscles and propagate upward into the large deep veins of the leg. It is the thrombus which extends from the popliteal vein upward into the femoral and iliac veins which usually results in fatal pulmonary embolism. Welch and Faxon,[13] in a study at the Massachusetts General Hospital, showed that the ratio of deaths to phlebitis was about 1 to 25. They also found that one patient in three with phlebitis would have an infarct, showing that after a warning non-lethal pulmonary embolus one out of eight may die of a massive pulmonary embolus.

Between 1937 and January 1, 1943 the femoral vein or veins have been interrupted in 202 patients at the Massachusetts General Hospital. In some patients unilateral operations were done, and in others bilateral operations, bringing the total of deep veins interrupted up to 280.

Table I

Number of Femoral Vein Interruptions in 202 Patients

Massachusetts General Hospital
(According to Year)

| | |
|---|---|
| 1937 | 1 |
| 1938 | 0 |
| 1939 | 8 |
| 1940 | 5 |
| 1941 | 55 |
| 1942 | 211 |
| Total | 280 |

The tremendous increase from 55 interruptions in 1941 to 211 in 1942 is due to increased confidence in the procedure, the greater alertness in detecting early signs of venous thrombosis and an increase in the number of bilateral operations. The age distribution is shown in Table II.

Table II

Age of Patients in Decades

202 cases of thrombo-embolic disease

Massachusetts General Hospital—1937-1942 (inclusive)

| | | | |
|---|---|---|---|
| 0-10 | 1 | 0.5% | |
| 10-20 | 4 | 2% | 19% |
| 20-30 | 9 | 4% | |
| 30-40 | 24 | 12% | |
| 40-50 | 37 | 18% | |
| 50-60 | 53 | 26% | 81% |
| 60-70 | 49 | 24% | |
| 70-80 | 25 | 13% | |
| Total | 202 | | |

Welch and Faxon[13] showed that the danger of fatal embolism was in direct ratio to the patient's age. It will be noted that 81% of the patients receiving femoral vein interruption were over 40 years of age. This greater incidence of the operation in this group of patients is explained by the fact that venous thrombosis occurs more frequently in patients past middle life. An analysis of the veins interrupted is shown in Table III.

It will be noted that the superficial femoral vein was more commonly interrupted than the common femoral vein. We thought that the former would result in less disturbance to the venous circulation of the extremity, which explains the greater incidence of superficial femoral vein interruption. As

Table III

Analysis of 202 Cases Thrombo-Embolic Disease treated by femoral vein interruption

Massachusetts General Hospital—1937-1942 (inclusive)

| | | | | |
|---|---|---|---|---|
| Number of Veins Interrupted: | | | | |
| Right Common Femoral | 27 | | 20% | |
| Right Superficial Femoral | 103 | | 80% | |
| Total (right) | | 103 | | 46% |
| Left Common Femoral | 39 | | 25% | |
| Left Superficial Femoral | 111 | | 75% | |
| Total (left) | | 150 | | 54% |
| Total | | 280 | | |
| Number of unilateral operations | 124 | | 61% | |
| Number of bilateral operations | 78 | | 39% | |

a result of the follow-up study on these patients, it has been observed that as far as edema is concerned, it makes little difference after a period of a year whether the superficial or common femoral vein has been interrupted. Interruption of the vein above the profunda femoris branch gives added protection against embolism from this large vein. For these reasons I have interrupted the common femoral vein more frequently in the past year than superficial femoral vein. If the venous thrombosis involves the common femoral vein it is preferable to interrupt it, whereas in early cases of venous thrombosis, involving only the calf veins, interruption of the superficial femoral vein is justifiable, since none of our cases developed fatal embolism following this procedure.

One of the most difficult problems in handling these cases of thrombo-embolic disease is the early detection of venous thrombosis in the calf. Early in the course of this study many phlebograms were done in an attempt to visualize by the injection of a radio-opaque solution, diodrast, the presence of thrombosis which could not be detected clinically. Welch, Faxon and McGahey[16] in our clinic felt at the time of their publication that this was a reliable method of diagnosis in questionable cases. With more experience in detecting early venous thrombosis, there has been a definite trend to rely less on this test as time goes on. Phlebography is not without its dangers. One case is of considerable interest in this respect. A postoperative patient, in whom venous thrombosis and pulmonary embolism was suspected, had bilateral negative phlebograms and two days later died of a fatal pulmonary embolism. As a result of this case, it was decided that even in the presence of negative phlebograms interruption of the femoral veins was indicated. Without question the radio-opaque solution, diodrast, is an irritant to the intima, since in another case complete venous thrombosis of the saphenous vein from the ankle to the groin was observed. During the past year of 1943, phlebograms have been done only in one per cent of the patients suspected of deep thrombosis. It is a time consuming test, requiring the cooperation of several individuals, and the observation that the interruption of the femoral vein interferes very little with the venous return of the lower extremity has led us to give up this test in the average case.

In Table IV an analysis of the phlebograms is shown.

Table IV

Phlebograms

| | | | |
|---|---|---|---|
| Positive with Positive Clinical Findings | 55 | | 67% |
| Negative with Positive Clinical Findings | 27 | | 33% |
| Total | | 82 | |
| Positive with Negative Clinical Findings | 19 | | 41% |
| Negative with Negative Clinical Findings | 27 | | 59% |
| Total | | 46 | |
| Positive with Pulmonary Emboli | 33 | | 49.3% |
| Negative with Pulmonary Emboli | 34 | | 50.7% |
| Total | | 67 | |
| Positive Phlebograms | 78 | | 54% |
| Negative Phlebograms | 67 | | 46% |
| Total | | 145 | |
| No. Femoral Veins Interrupted—1941 | | 53 | |
| No. Phlebograms—1941 | | 36 | 68% |
| No. Femoral Veins Interrupted—1942 | | 211 | |
| No. Phlebograms—1942 | | 104 | 50% |
| No. Femoral Veins Interrupted—1943 | | 299 | |
| No. Phlebograms—1943 | | 3 | 1% |

It will be noted that even with positive clinical findings, 33 per cent of the phlebograms were negative. This is probably explained by the fact that phlebography is not accurate in visualizing venous thrombosis involving only the calf veins. In addition many of them are equivocal, so that it is difficult to be absolutely sure whether the x-ray picture shows a definite thrombus or whether it is an artifact.

The indications of deep venous thrombosis are shown in Table V.

Fifty-nine per cent of the cases had leg signs or symptoms as the first indication of venous thrombosis, while 41 per cent had chest pain first. It has been pointed out by Allen[17] that when the clinical chart shows a synchronous elevation of temperature, pulse and respiration one should examine the

Table V

Indications of Venous Thrombosis

| | | |
|---|---|---|
| No, of cases with chest pain as first symptom | 82 | 41% |
| No. of cases with leg signs as first symptom | 120 | 59% |
| No. of cases with suitable charts for study | 74 | |
| No. of cases with positive clinical chart noted | 60 | 81% |
| No. of extremities examined for swelling | 237 | |
| No. of extremities showing swelling | 159 | 67% |
| No. of extremities examined for tenderness | 231 | |
| No. of extremities showing tenderness | 143 | 61% |
| No. of extremities examined for Homans' sign* | 139 | |
| No. of extremities showing positive Homans' sign | 59 | 42% |

*Homans' sign is a term used in our clinic. Dr. John Homans calls it the dorsiflexion sign. It is carried out by dorsiflexion of the foot with the knee straight. If the patient complains of pain or soreness in the calf muscles when this is done, the sign is interpreted as positive for venous thrombosis.

patient's legs with the utmost care. If minimal signs are found in a patient who is making a satisfactory postoperative convalescence, bilateral femoral vein interruption is indicated. It is important that the elevation in temperature, pulse and respiration be simultaneous. When it occurs it is thought to indicate the presence of a small pulmonary embolism. It will be noted that the presence of swelling was the most frequent indication of venous thrombosis; 67 per cent of the cases examined showed it. The next most frequent indication was tenderness in the calf; this was present in 61 per cent of the cases examined. Since no one of the indications was present in 100 per cent of the cases, it is important in a suspected case of venous thrombosis that examination of the clinical chart for a concomitant rise in temperature, pulse and respiration, and examination of the lower extremities for swelling, pain and tenderness, should be carefully and frequently made. A certain number of patients develop pulmonary infarction as the first signs of venous thrombosis. As a rule the roentgenological picture of an infarct is characteristic.[15] The location of the infarct is an important diagnostic aid in differentiating it from other pulmonary conditions. An analysis of the location of the pulmonary infarcts in this group of patients is shown in Table VI.

Table VI

Location of Pulmonary Emboli

| | | |
|---|---|---|
| Left Lower Lobe | 66 | 69.5% |
| Right Lower Lobe | 41 | 36.9% |
| Left Upper Lobe | 3 | 2.7% |
| Right Middle Lobe | 0 | 0 |
| Right Upper Lobe | 1 | 0.9% |

It will be noted that the majority of them occur in the lower lobes of the lungs; the left is more frequently involved than the right. It is thought by Klopstock and Wolff[18] that this is due to the fact that the blood flow is more rapid to the lower lobes than the upper lobes, so that a large object such as a thrombus is more likely to lodge in the lower lobes. The rarity of embolism of the upper lobe thus may be of value in ruling out pulmonary embolism when a questionable lesion is found in this location.

There were a few minor infarcts after femoral vein interruption. Eleven of the 202 patients had this complication. Massive fatal pulmonary embolism did not occur following bilateral femoral vein interruption. The treatment of choice in patients with minor pulmonary infarction, following femoral vein interruption, is the administration of an anticoagulant, either heparin or dicoumarol. We have favored the former, since it is more readily controlled, although somewhat more difficult to administer.

There were 12 deaths in this group of 202 patients. None of them succumbed to massive fatal pulmonary embolism following interruption of the femoral veins except in one instance, in which the embolus arose from the uninterrupted vein in the opposite leg. The mortality rate of the operation of femoral vein interruption was zero, as no deaths were directly attributable to the operative procedure.

At first thought aspiration of the thrombus from the iliac vein seems a hazardous procedure, in case a portion of the clot is dislodged by the insertion of the glass cannula. In no instance, however, did this result in the group of 86 patients in whom thrombi were found in the femoral veins at operation. This obviously demonstrates the safety of aspiration of proximal thrombi. It should be emphasized that the cannula used is a large, angulated glass one, approximately the size of the femoral vein. The transparency of it enables one to observe the removal of the clot as the cannula is inserted. If the cannula or tubing become occluded by large clots, further insertion of the cannula is contraindicated as this might dislodge a thrombus to produce embolism. During the operation the patient's trunk is elevated to insure a positive venous pressure at the groin so that thrombi will be forced distalward rather than be aspirated towards the heart.

Serious sequelae following femoral vein interruption have rarely been noted. Persistent edema is the most common one, but certainly it is no greater than if the phlebitis, especially in the femoral iliac group, has been allowed to run its natural course. It is our impression at the present time that the

postoperative edema diminishes more rapidly after aspiration of the thrombus than if conservative treatment were carried out. If the operation can be performed in the femoral iliac group within twenty-four hours of the time of thrombosis in this region, the collateral venous channels will be reopened so that the edema will often subside rapidly. If the thrombus at this site is very adherent the edema does not disappear as rapidly, because the collateral channels remain occluded with thrombi which cannot be aspirated. For this reason early operation is indicated, both from the point of view of preventing further pulmonary emboli and also to insure a better immediate postoperative result in the extremity. In Table VII a follow-up study of the postoperative edema, following femoral vein interruption, is tabulated.

TABLE VII

POSTOPERATIVE EDEMA FOLLOWING FEMORAL VEIN INTERRUPTION

Massachusetts General Hospital—1937-1942 (Inclusive)

| | NO. OF CASES | NUMBER WITH | | NUMBER WITHOUT | |
|---|---|---|---|---|---|
| **IMMEDIATE EDEMA** | | | | | |
| Right Common Femoral.. | 19 | 13 | 70% | 6 | 30% |
| Left Common Femoral.... | 34 | 29 | 85% | 5 | 15% |
| Total | 53 | 42 | 80% | 11 | 20% |
| Right Superficial Femoral | 78 | 37 | 47% | 41 | 53% |
| Left Superficial Femoral.. | 82 | 39 | 48% | 43 | 52% |
| Total | 160 | 76 | 47.5% | 84 | 52.5% |
| **LATE EDEMA** | | | | | |
| Right Common Femoral.. | 6 | 2 | 33% | 4 | 67% |
| Left Common Femoral.... | 20 | 10 | 50% | 10 | 50% |
| Total | 26 | 12 | 46% | 14 | 54% |
| Right Superficial Femoral | 26 | 8 | 31% | 18 | 69% |
| Left Superficial Femoral.. | 31 | 16 | 52% | 15 | 48% |
| Total | 57 | 24 | 42% | 33 | 58% |

It will be noted that immediate edema following the operation is more frequent after common femoral interruption, compared with superficial femoral vein interruption. After a period of a year there seems to be little difference in the amount of edema, whether the common femoral or superficial femoral vein has been interrupted. It should be pointed out that after this period of time, although the incidence of edema was in the neighborhood of 45 per cent, the swelling was actually minimal and practically all the patients had discarded any form of supporting bandage or elastic stocking.

So far we have observed only one transient postphlebitic type of ulcer. It is planned, in fact, after a five or ten year period to check the cases in reference to ulcer formation, as it is hoped that femoral vein interruption may prevent postphlebitic varicose ulcerations of the lower legs.

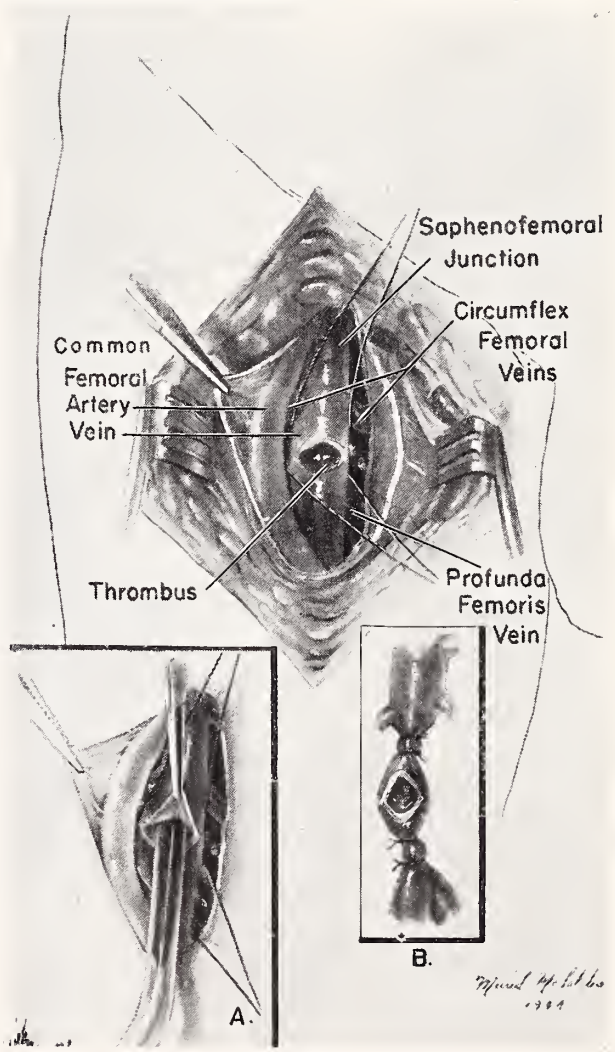



FIG. 1

A schematic drawing to show the exposure of the common femoral vein. The vertical skin incision is made directly over the femoral vessels extending proximal to the groin crease. The inguinal lymph nodes and the femoral artery are retracted lateralward and the saphenous vein medialward. Note the two traction sutures placed proximal to the profunda femoris vein and distal to the circumflex femoral veins. The thrombus is seen protruding through the transverse incision in the common femoral vein.

Inset A. shows the aspiration of the thrombus from the proximal segment using an angulated glass cannula.

Insert B. shows the quadruple ligation in continuity of the common femoral vein after thrombectomy. The wound is closed without drainage in layers with fine interrupted sutures of cotton.

The operation of femoral vein interruption is carried out as follows. The patient's trunk is slightly elevated to insure positive venous pressure at the level of the femoral vein. One per cent local procaine infiltration anesthesia is used. The incision follows the course of the femoral artery, which is readily palpable in the groin. It extends an inch above the crease in the groin and about three inches distal to it. With this type of incision the lymphatics are not damaged, as may occur when a transverse or more oblique exposure is used. The saphenous vein is carefully preserved and not traumatized; it is retracted medialward and the femoral lymph nodes lateralward, exposing the fascia lata of Scarpa's triangle. This is incised exposing the femoral sheath, which is opened longitudinally, bringing into view the femoral artery and vein. The artery is separated from the vein and retracted lateralward. Two ligatures are passed around the common femoral vein proximal to the profunda femoris branch, carefully avoiding the large medial and lateral circumflex branches which arise posteriorly (Fig. 1). If a thrombus is found the vein is opened transversely through about a third of its circumference. The thrombus usually is partially extruded by the positive venous pressure. The remainder is then withdrawn by aspiration through the glass cannula. The upper segment is always aspirated first. Every attempt is made to clear the proximal segment so that free bleeding from above is obtained, indicating complete removal of all thrombi. In an occasional case, this will be impossible. The introduction of the aspirating cannula proximally has never dislodged the thrombus. After aspirating the proximal segment the distal segment is similarly treated. This is not so important, but it is felt that it aids in the reduction of the edema since more collateral venous channels are reopened. The previously placed ligatures are then tied but the vein is not divided. Cotton or silk ligatures are used routinely, since it is important that the vein does not recanalize. It would be preferable to divide the common femoral vein, but the segment is so short and there are so many branches arising from it that it is not practical to do this. Secondary hemorrhage from ligation in continuity of the femoral vein and inferior vena cava has not occurred, as it frequently may do in the case of major arteries. Presumably this is because the venous pressure is much lower than the arterial pressure. If no thrombus is encountered the vein is doubly ligated in continuity without opening it.

Bilateral femoral vein interruption requires about forty-five to sixty minutes. The patients are allowed out of bed as soon as they become afebrile or their general condition permits. This is often on the day following the removal of a bland thrombus. In an occasional case we have been troubled with a short period of lymph drainage through the wound.

It is our opinion that we have saved patients' lives from fatal pulmonary embolism by means of femoral vein interruption. In addition, the morbidity of thrombophlebitis of the lower extremities has been greatly reduced. In Table VIII are tabulated the morbidity statistics in cases of thrombo-embolic disease treated by vein interruption.

Table VIII

Morbidity Statistics in Cases of Thrombo-Embolic Disease Treated by Vein Interruption

Massachusetts General Hospital—1937-1942 (Inclusive)

| | | |
|---|---|---|
| I. | Days after vein interruption to flat chart: | |
| | No. of cases | 162 |
| | Average no. of days | 4.5 |
| II. | Days after ligation to discharge from hospital: | |
| | No. of cases | 84 |
| | Minimum no. of days | 3 |
| | Maximum no. of days | 13 |
| | Average no. of days | 8.4 |

The cases tabulated include the ones which were being kept in the hospital only because of the femoral vein operation and does not include cases of fractures, heart disease and complicated surgical procedures which demanded longer hospitalization. They are not selected and we believe they represent a true picture of the situation. It will be noted that the average number of days after vein interruption until the patient had a flat chart was 4.5. This should be compared to the average duration in a conservatively treated case of thrombo-embolic disease, which requires usually from two or three weeks at least before the chart is flat. Similarly, it will be noted that in 84 such patients the average number of days after ligation to dischrage from the hospital was 8.4. Thus it is obvious that there is a great saving in hospitalization, as well as protection from pulmonary embolism by means of this relatively simple procedure.

Homans[19] believes that there is less edema following interruption of the common iliac vein. He believes the reason for this is the greater number of collateral venous channels in this region. In a certain number of cases of long standing thrombophlebitis involving the iliac veins with pulmonary infarction,

it is our belief that the venous circulation should be interrupted at a higher level than the femoral vein, since it is impossible, because if the adherence of the thrombus to this vein, to clear completely the venous channels through the femoral veins. In these cases the Homans' operation of division of the common iliac vein is definitely superior, since it is possible to interrupt the venous channels proximal to the thrombus formation. He recommends a long oblique ureteral type of abdominal incision, exposing the iliac veins retroperitoneally. The right common iliac vein is readily exposed by this route but the left, which lies posterior and medial to the artery, is more difficult to approach. Because of this difficulty of exposure, especially on the left, and since the common iliac vein interruption requires two incisions, one on each side, interruption of the inferior vena cava, just above its bifurcation, has been adopted in our clinic by preference. *It is emphasized that this operation should be reserved for the exceptional and rare case.* Certainly it is not indicated in the ordinary case of venous thrombosis of the calf, since femoral vein interruption has been shown to give adequate protection in these cases. In addition, many of the postoperative group of patients are too ill to withstand the major operation of exposing the inferior vena cava, whereas the femoral vein can readily be exposed under local anesthesia and if necessary with the patient in bed and in an oxygen tent. To the present date, ten inferior vena cava interruptions have been performed. No serious sequelae have resulted. Eight of the ten patients are living and well. The two deaths were not attributable to the inferior vena cava ligation. The oldest one, which was operated on in April 1943, is leading an active normal existence. Spinal anesthesia is preferred in these cases. The vena cava may be exposed through a transperitoneal approach, but more preferably through an extraperitoneal approach through either a right paramedian incision or a flank incision. A right paramedian approach retracting the peritoneum out of the iliac fossa gives excellent and adequate exposure and is believed to be the method of choice.

## SUMMARY AND CONCLUSIONS

1. Bilateral femoral vein interruption for the prevention of pulmonary embolism is a safe procedure which will prevent massive fatal pulmonary embolism in patients with deep venous thrombosis of the lower extremities.

2. This operation should be carried out on (1) patients who have developed nonfatal pulmonary embolism, even though no positive signs of venous thrombosis in the legs can be detected and (2) on any patient who develops deep phlebitis of the lower extremities. It is rare that all the signs of phlebitis are present, so that the decision to operate may depend on one or two criteria.

3. Bilateral femoral vein interruption should be done on all patients with deep venous thrombosis even if the diagnosis is made only in one extremity, because frequently a thrombus is found in the unsuspected femoral vein, and since one case from our clinic and several from other clinics following unilateral femoral vein interruption have died from a massive pulmonary embolus which arose from the unligated side.

4. The diagnosis of thrombophlebitis should be made if possible before the femoral and iliac veins have become involved, since the postoperative sequelae are reduced.

5. Thrombectomy by aspiration in cases with femoral iliac thrombosis has been demonstrated to be a safe procedure. It should be done as early as possible after the thrombosis has been diagnosed. It reduces the pain and swelling in the leg and hastens the recovery, in addition to preventing massive fatal pulmonary embolism.

6. No deaths have occurred in the group of 202 cases reported as the result of femoral vein interruption.

7. The morbidity of thrombo-embolic disease is tremendously reduced by this operation.

8. Interruption of the inferior vena cava distal to the renal veins is the operation of choice in cases of long standing thrombophlebitis with pulmonary embolism.

The author wishes to express appreciation to Arthur W. Allen, M.D., Gordon A. Donaldson, M.D., Annals of Surgery and J. B. Lippincott Co. for permission to use the tables in this article, which was published in Annals of Surgery 118:728 (Oct.) 1943.

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# PRESENT TRENDS IN THE TREATMENT OF VARICOSE VEINS

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THE METHODS currently employed in the treatment of varicose veins too frequently give results short of the ideal. For some time this fact has been quite obvious to the family physician, but it has been accepted unwillingly by the surgeon because the procedure of high ligation with retrograde injection originally gave such promise of being the rational and ultimate treatment for all varicose veins.

The faulty results from the present methods of treatment are of two kinds. The first is a recurrence of the varices within a few months or years following the treatment. This appears to be due to inadequacy of the treatment and to the formation of new varicosities. The second is the development of thrombophlebitis or some form of edema and an inflammatory reaction in the tissues some time after the treatment. This appears to be an activation of a latent or smouldering inflammatory process, an independent disorder, the nature of which is only now beginning to come to light.

A large proportion of the difficulties in the treatment of varicose veins might be resolved if one could prevent the recurrences in those cases in which surgical procedures for the eradication of the veins are clearly indicated, and if one were able to recognize and avoid surgery in the cases which are apt to do poorly with present methods, particularly those which are prone to develop a recrudescence of the phlebitic disease.

## THE CAUSES OF VARICOSE VEINS

The causes of varicose veins need further investigation. The etiological factors which are listed most commonly are: (1) a hereditary lack of valves or a weakness of the walls of veins in the neighborhood of valves; (2) trauma to veins and valves; (3) a long continued postural strain overdistending the veins; (4) continual compression or constriction of veins leading to stasis and increased venous pressure; (5) thrombophlebitis or the effects of inflammation in general about vessels; and (6) pregnancy and parturition.

*Presented at the 20th Clinical Congress of the Connecticut State Medical Society, September 29, 1944*

Several recent studies on the etiology of varicosities are worth noting here. Eger and Casper[2] studied in 38 adult cadavers the number of valves of the external iliac and femoral veins to the level of the orifice of the great saphenous vein. They assumed that an absence of valves in these veins would impose too great a burden on the valves at lower levels and contribute to the formation of varicose veins. On the basis of these observations they ventured the following predictions: there is a 36.8 per cent minimal potential incidence of varicose veins in the lower extremities; the varicosities should develop unilaterally in 28.9 per cent and bilaterally in 7.9 per cent; and the left leg should be involved twice as frequently as the right. (See Table 1.)

Table 1

EGER AND CASPER'S TABLE ON THE DISTRIBUTION OF VALVES IN EXTERNAL ILIAC AND FEMORAL VEINS PROXIMAL TO THE ORIFICE OF THE INTERNAL SAPHENOUS VEIN IN 38 CADAVERS

| NO VEIN CONTAINED MORE THAN ONE VALVE | | NUMBER | PER CENT |
|---|---|---|---|
| Absent bilaterally | | 3 | 7.9 |
| Absent unilaterally | total | 11 | 28.9 |
| | right | 4 | 10.4 |
| | left | 7 | 18.5 |
| Total of absent valves on one or both sides | | 14 | 36.8 |
| Absent in right external iliac, but present in femoral | | 21 | 55.2 |
| Absent in left external iliac, but present in femoral | | 20 | 52.6 |
| Absent bilaterally in external iliac, but present in femoral | | 14 | 36.8 |
| Absent bilaterally in femorals, but present in external iliac | | 0 | 0 |
| Absent in right femoral, but present in external iliac | | 4 | 10.4 |
| Absent in left femoral, but present in external iliac | | 2 | 5.2 |

These predictions may be compared with data from a report by Lake, Pratt, and White[4] on the incidence of varicose veins in 537 working people over 40 years of age. In this carefully studied group of people 40 per cent of the men and 70 per cent of the women had pathologic varicose veins which were causing symptoms. When those women who had had pregnancies (a long recognized etiological factor) were eliminated, the incidence among women was still 60 per cent. Women who stood or walked at work showed a slightly higher incidence of varicose veins than women who sat at their work. This was not true in men.

From this study on the actual incidence of varicose veins in a middle aged group of people, one concludes that the predictions based upon the anatomical studies are realized in men, but in women still other factors are added to make them more susceptible than men. The objection to this simplification of the etiology of varicose veins is that it does not include any of the cases related to phlebitis.

It is not difficult to see that either thrombophlebitis, periphlebitis, or simple thrombosis of veins, leading to an inflammatory reaction about the valves, or to thrombi in the lumen in a valve area, will lead to loss of function of valves and ultimately to varicose veins. A thrombosis of a long segment of a vein is sure to cause the loss of function of a whole series of valves, and when the vein recanalizes, as it promptly does, the system of veins below becomes dilated and later varicose. Thrombosis has long been associated by pathologists with infection, and the classical illustration of a thrombus propagating into a large from a small vessel adjacent to an inflammatory focus is familiar to all medical students. This simple mechanism of propagation of the clot does not explain all clinical examples of thrombosis. Some of these have been shown to be due to an unusual sensitivity of the clotting mechanism and others to an excessive vulnerability of the endothelium to a special type of degeneration which provides a focus for a thrombosis. There are experimental grounds for believing that a hypersensitive state of the endothelium may predispose to its injury and therefore to thrombosis, when it is exposed to the antigen to which it is sensitive. Parturition, through the effects of hemorrhage which increases the clotting tendencies, infection which may sensitize endothelial cells, and involution of vascular structures which provides large reservoirs of blood relatively stagnant in flow, is therefore quite naturally a period for the development of thrombophlebitis.

It is surprising that in women who have not been pregnant the incidence of varicose veins is as high as it is. It would seem that the endocrine factor which women as a group possess, rather than the special hazards of pregnancy, is the more important cause of the varicose veins of women. It is interesting to note here that varicose veins are very common in eunuchoid men.

Pregnancy and the post-partum state and the female hormonal constitution clearly have some very definite, though as yet intangible, etiological relationship to the formation of varicose veins. It is easy to assume that the pressure of the enlarging uterus on the pelvic veins may be the basic cause for the development of varicosities during pregnancy, but I am inclined to doubt this explanation. Not many years ago the dilatation of the ureters in pregnancy

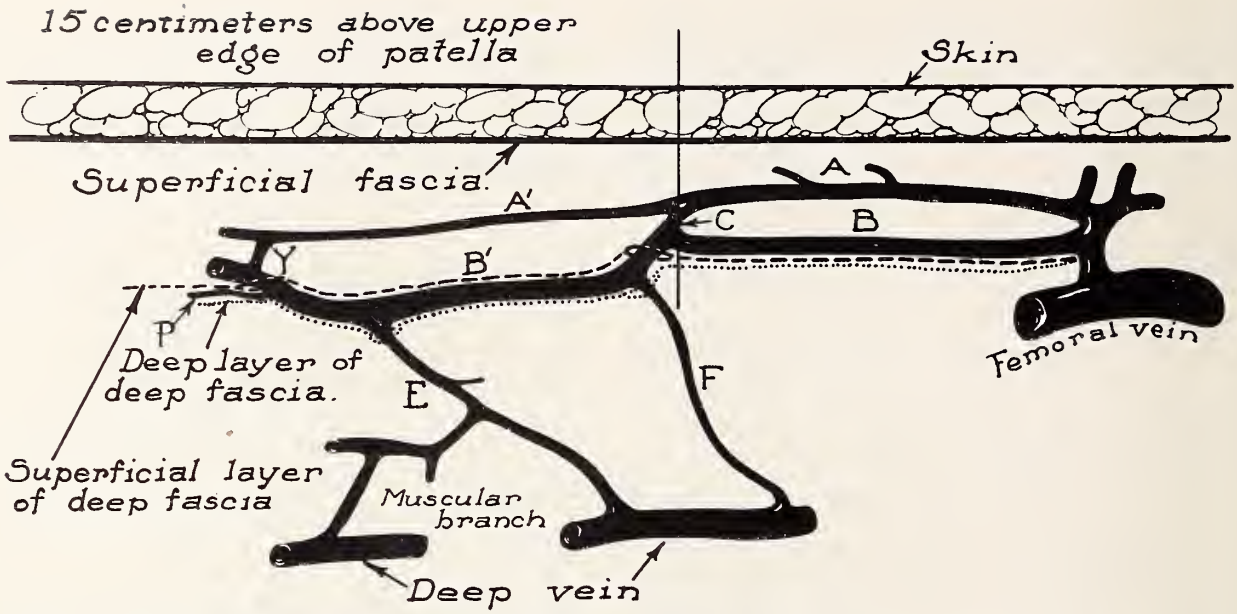



Fig. 1.—Type I: From Cadaver Dissection. The main stems of the saphenous system are shown as AA' and BB'. Note that proximal to connector Vein C, Vein B lies superficial to the superficial layer of the deep fascia, and that distal to Vein C, Vein B' lies between the fascial layers. Perforator veins are shown coming off from Vein B'.

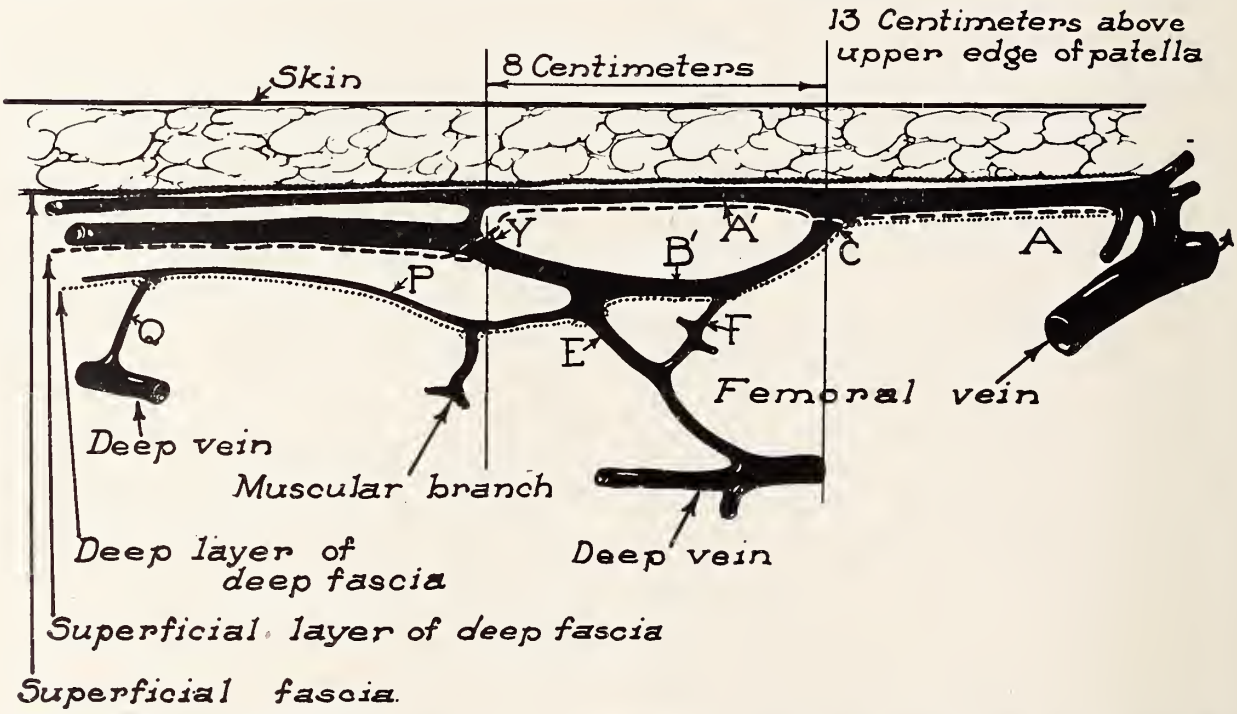



Fig. 2.—Type II: From Cadaver Dissection. Note that Vein B is absent. The branch P from Vein B gives off an additional perforator vein (Q).

PLATE I

Sherman's illustrations of his Types I and II of the saphenous system and its communications with the deep system.

was believed to be due to the pressure of the enlarging uterus. This supposition was found to be erroneous. Progesterone, a hormone which aids in the maintenance of pregnancy, is probably the cause of this ureteral dilation, because it causes a pronounced dilation of the ureters even in the absence of the uterus. We may yet discover that one of the side effects of this or related steroid hormones is to relax all vessels, permitting them to dilate, and thus in women and especially in pregnant women to predispose to varicose veins. These questions wait final answers.

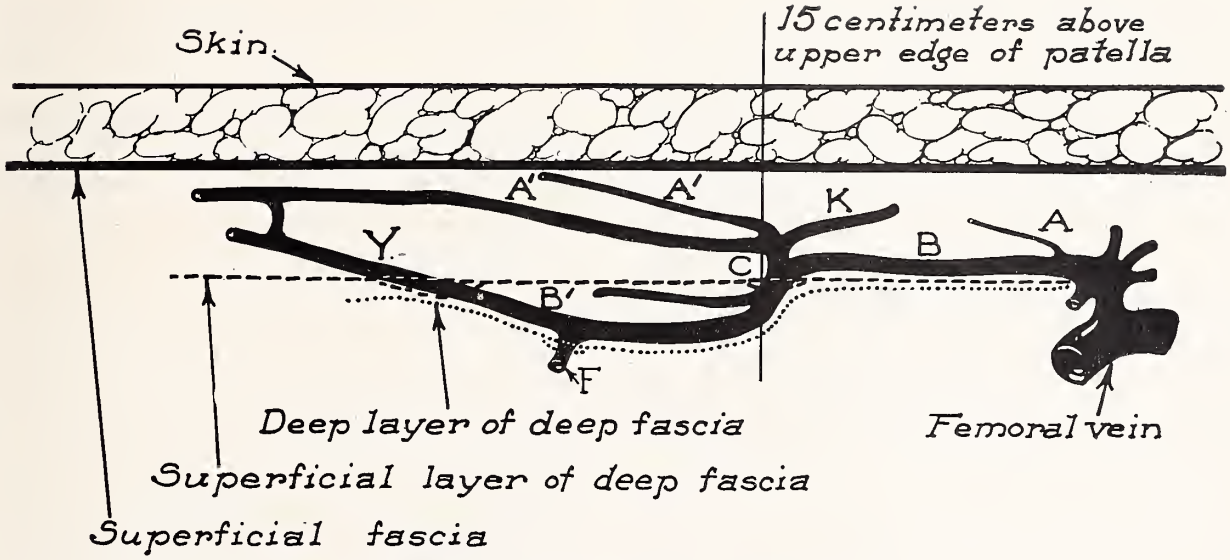



Fig. 3.—Type III: From Surgical Dissection. Note that Vein A is rudimentary.

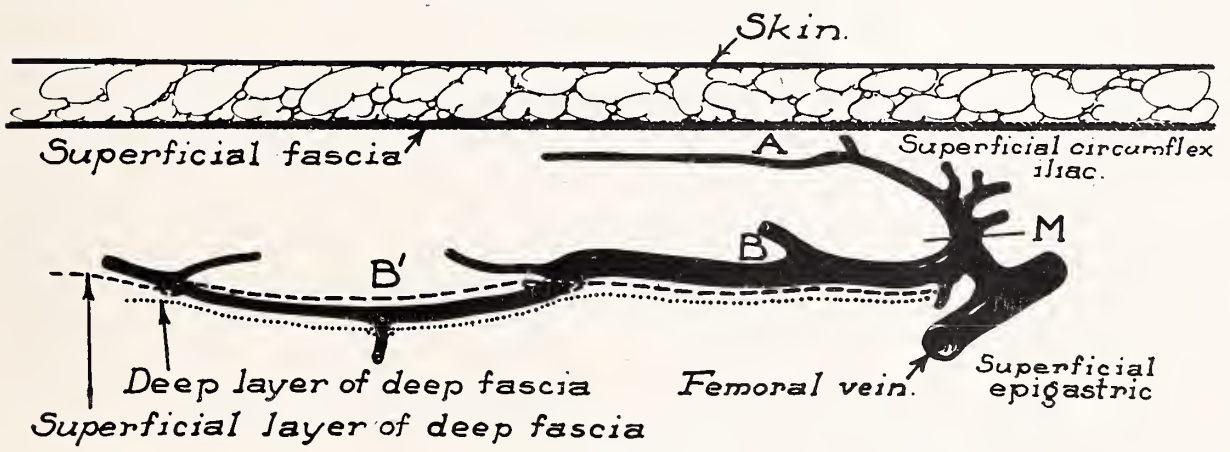



Fig. 4.—Type IV: From Surgical Dissection.—This figure illustrates danger of mistaking a superficial vein (A) for the main saphenous when ligation of the saphenous vein alone is practiced. (See text.)

PLATE II

Sherman's illustrations of his Types III and IV variations of the saphenous system and its communications with the deep system.

## THE EFFECTS OF VARICOSE VEINS

Varicose veins are disfiguring and sometimes cause real symptoms, which may vary a good deal in severity from a mild sense of heaviness of the limb and fullness of the veins, to cramps in the muscles of the leg and aching sensations in the very full veins. Patients with enormous varices may have spells of faintness or syncope shortly after standing, because of the sudden puddling of blood in the dependent varices. In other cases the heavy, full, fragile varices are easily traumatized, and this may lead to extravasations of blood and thromboses or severe external hemorrhage traumatized, thrombosed vein is tender to touch and sensitive to changes in pressure in its lumen.

It is a mistake however, to blame varicose veins for all the aches and pains to which a limb is subject. One must have very good grounds to incriminate varicose veins if the symptoms one aims to relieve are not improved by some trial-method which collapses the veins.

The blood runs downward instead of upward in a varicose saphenous vein, and when the subject is standing, the $CO_2$ content in a varicose vein is lower than in a normal vein.[1] The oxygen tension is higher, however. There is a tendency for edema of the foot when the venous pressure is elevated, but in uncomplicated varicose veins with the patient in the erect position the venous pressure is not as high as it is when the patient is horizontal. This is due to the fact

that patients with large varicose veins have a greater than normal blood volume. At any rate, neither venous pressure nor the oxygen values in the venous blood have yielded convincing proof that a varicose ulcer is due to lack of oxygen in the tissues. Indeed, the evidence indicates that in ulcer cases the blood supply of the limb in general is increased[1,3] although there probably are sharp local circulatory deficiencies in the areas of necrosis themselves. Normally the lymphatic system can accommodate for an enormous increase in the production of lymph under the stress of an increased venous pressure. It is only when the lymphatic system also is diseased that the increased filtration rate caused by varicose veins shows itself as an edema of the leg or foot.

### THE PHLEBITIC SYNDROME

One of the oldest practical observations on the varicose and phlebitic ulcerations is that they tend to heal when the part is elevated enough to relieve congestion of blood and edema fluid. Conversely, in most cases, the ulceration tends to recur some time after the patient resumes activity. The relief of venous congestion by a well devised procedure tends to cause permanent healing of a certain group of ulcerations, and these are termed varicose ulcers, but in another group distinguished only by the history of phlebitis or certain other inconstant events the ulceration usually recurs even after the most painstaking procedures by the most expert surgeons.

Although much effort has been expended experimentally to incriminate the congested veins as the cause of the ulcerations and the edema that so often accompanies them, we may have to reject the whole idea that the venous congestion causes the ulceration. It now seems more plausible that the process responsible for the ulceration is also responsible for the disease of both the lympathic and the venous systems. There are probably two entirely different groups of cases with varicose veins: viz., those uncomplicated cases due to congenital, occupational, hormonal and traumatic factors; and those associated with the peculiar inflammatory disorder known as the phlebitic syndrome. The latter may be superimposed on the former.

Homans, DeTakâts, and others have long taught that the injection of sclerosing solutions in veins of patients with the postphlebitic state is harmful. Pratt states,[6] "it is important to emphasize that varicose veins as a result of phlebitis are a different type of vein; the treatment must be varied, and the results cannot be as satisfactory as in the simple varicosities."

I have concluded that the case suspected early of having the taint of the phlebitic syndrome probably should be treated conservatively for several months or even longer until the phlebitic syndrome is quiescent before treating the veins. During this time the patient is instructed to take perfect care of the extremities, all foci of infection are eradicated, and the edema is controlled by the wearing of elastic stockings and other devices.

### INDICATIONS FOR THE TREATMENT OF VARICOSE VEINS

Huge dilated varicose veins have no function, and indeed, as Homans and others have so often stated, because of the burden of blood they carry downward they overtax the function of the deep veins. Therefore they are best removed or obliterated. This applies to the whole group of cases with large and unsightly veins in which the symptoms vary from mild heaviness to actual faintness on standing. There is no difficulty in these cases in reaching the decision that treatment is indicated; the only question may be what procedure will do the most good.

Another variety is that group of veins that are easily visible in the subcuticular tissues. They are magnified telangiectases, and some are known as spidery "bursts." Most of these are amenable to injection therapy. The "burst" may be obliterated very satisfactorily by the careful injection of a small quantity of a sclerosing solution, and success is dependent upon a perfect injection of the previously emptied central collecting vein.

*The next category of cases that should not be too difficult to segregate is one that should not be treated by surgical methods at all. Between these two extremes is a group in which the best methods for treatment are not clearly defined.* True varicose veins, that is, dilated veins without valves, are ineffective and useless for the return of blood. However, after an obstruction of the deep femoral vein, the obliteration or ligation of the collateral—the superficial—veins would be harmful. Therefore, in the period before the recanalization of the femoral obstruction, the obliteration of varices of the superficial system is contra-indicated. Injections in this situation would be futile, and a saphenous ligation would cause marked venous engorgement and for a time a precarious leg until collaterals could form.

Another contra-indication is a recent exacerbation of the phlebitic syndrome. If a saphenous ligation, or any surgery for that matter, is attempted during activity of the phlebitic syndrome, a serious exten-

sion of the phlebitic disease may occur. We do not yet know how to predict these unfavorable occurrences, but until progress in this is made we should hesitate to carry out elective surgical procedures until the phlebitic syndrome has burned itself out.

The borderline cases always are the most perplexing. What about mild or very old or suspected cases of the phlebitic syndrome? What about patients who notice the beginning of varices and want to prevent their further development?

So far as I am aware, no one knows what to do to prevent the development of varicose veins, or what is best to do to halt their progress when once they begin to appear. I tend to believe that ligations and injections done early often fail to halt the progress of the varices. This whole situation will be ready for evaluation in a few years when the results are available on the current widespread preventive treatment of varicose veins of young women in industry.

In selected cases of phlebitic ulceration or phlebitis it may be necessary to run the risk of the flare in other parts in order to carry out some surgical procedure aimed to benefit some particularly bothersome lesion. In excising patches of phlebitis or in vein division or in any other surgery in these cases it is essential that absolute asepsis be maintained and that trauma be minimal. If phlebitic patches are to be excised they should be completely excised. There is a lot to be said for the precise surgical excision of a tender patch of thrombosed veins. The surgical wound may be less bothersome than the phlebitic vessel, and take less time to heal.

### METHODS FOR TREATING VARICOSE VEINS

There are three types of methods available for the treatment of varicose veins, viz.: operative excisions or divisions of the veins; (2) injections with chemicals designed to sclerose and obliterate the lumen of the vein; and (3) conservative measures involving compression of the legs and the veins with elastic bandages, stockings, or other materials.

*The palliative treatment by elastic compression in many patients is surprisingly effective in controlling the symptoms and effects of varicose veins.* The method is inconvenient, however, and sometimes it has to be abandoned altogether because of the development of a dermatitis on the lower legs. On the other hand, in these days elastic stockings are light in weight and are relatively inexpensive. The person who is advised to use elastic compression can expect to have no trouble with the skin provided scrupulous attention is paid to the care of the skin of the feet and legs, particularly the mycotic lesions.

The methods for elastic compression of veins are often useful in estimating the efficacy of proposed obliterative surgical procedures. If the patient is able to wear a well fitted bandage on the leg without discomfort or swelling of the foot, it is obvious that the deep venous return is adequate. Further, if this simple measure gives relief from symptoms, it is likely that a surgical procedure aimed to obliterate the veins will give relief of these same symptoms.

In general the injection of sclerosing solutions in cases of the phlebitic syndrome leads to unfavorable results in a fairly high proportion of cases. The bad results are of three types, viz.: (1) the phlebitic syndrome may flare, showing itself as a deep thrombophlebitis of one or both legs; (2) the tissues at the site of the injection may break down and become necrotic, forming an ulcer which is difficult to heal; (3) long courses of injections are followed by widespread indurations, inflammatory reactions and edema, all very uncomfortable to the patient and difficult for the physician to treat.

A brief digression may be appropriate here to discuss the possible delayed reactions of tissues to some of the chemicals used for injections. There are a number of allergic reactions that tissues may show in response to chemicals. Tissues normally do not develop hypersensitivity to simple chemicals, but sometimes, when under the influence of very strong antigens, a tissue will develop a cross reaction with a very simple substance which normally would not induce hypersensitivity. The clinician is now quite familiar with the possible systemic, anaphylactic ill effects of hypersensitivity to sodium morrhuate. The commonly described reaction is an anaphylactoid one which may be quite alarming. Not much attention has been given to the possible delayed reactions that may be initiated in the tissues by this or related chemicals. In this process the tissues develop a tuberculin-like reaction or "delayed reaction of infection," which smoulders along for many weeks or months, and each area of reactivity may respond to exposures of the same chemical from injections in other parts of the body. The widespread reactions which may conceivably be set up by some of these sclerosing agents after multiple injections account for some of the bad results seen in the form of extensive inflammatory reactions and edema after long courses of injections. In patients

with the phlebitic syndrome the tissues already are subject to this delayed reaction of infection and are highly sensitized so that they react readily to new substances to which a normal person would not respond. Therefore in these cases particularly one should beware of introducing a new antigen which may do more harm than good. In these conditions the safest chemicals to use for sclerosing injections are glucose and saline in concentrated solution. Unfortunately, it appears that any trauma may set off this same delayed reaction of infection if the tissue's reactivity or hypersensitivity is very great. Therefore in such cases injections of any type are unsafe.

The most certain procedure for the obliteration of varicose veins would appear to be the surgical excision of all the large veins and the ligation of all their principal connections with the deep system. Variations of this method have been carried out by many surgeons for years, and the inescapable conclusion is that there is an appreciable mortality rate from postoperative pulmonary embolism. This is higher than in other types of treatment involving a minimum of surgery and some form of injection of a sclerosing chemical. Therefore, most surgeons of wide experience have tended to abandon the extensive surgical procedures and to adopt a substitute with a definitely lower mortality.

On the other hand we have accumulated enough experience with the late results of the procedure of "high ligation and retrograde injection" to indicate that there are too many cases that later develop recurrences of varices for us to be completely satisfied with it. These recurrences are difficult to deal with, and are believed due to the recanalization of the thrombosed vein with an influx of blood from one or more communicating veins having incompetent valves.

Whenever incompetent communicating veins of any size are present they must be ligated, otherwise the procedures aimed to obliterate the varices are bound to be a failure in the long run. However, the finding of the incompetent vein during the ligation procedure is not an easy task in an adipose leg, even when its presence and approximate location is known. Yet, despite these difficulties there has been a tendency of many of the younger surgeons, who are dissatisfied with the results of other methods, to rely more and more on careful division of these vessels and less on the injection following simple high ligation.

Sherman,[7] after analyzing his failures of treatment, carried out an extensive anatomical study of the superficial veins in the thigh, and as a result of this study has made certain suggestions which may be the answer to these problems. All surgeons who undertake vein ligations should be familiar with Sherman's work. The principal variations which he found in the saphenous system and in its connections with the deep femoral system are shown in illustrations which follow. One concludes after reviewing Sherman's work that it is necessary (1) to search for both of the possible saphenous veins and identify the true sapheno-femoral junction; (2) to locate Sherman's vein "C" in the region of the lower part of Hunter's canal; and (3) to remove his vein "B1," severing the communicating branches.

Although insufficient time has passed for Sherman's procedure to be checked in the light of final results, his suggestions appear to offer a solution to the problem of recurrences. His dissections wipe away some of the mysteries surrounding the communicating vessels of the thigh. Sherman's studies appear to have been confirmed in part by Lesser and Danelius[5] who have reported venographic studies of the anomalies of the saphenous system.

The operation that is the logical outcome of Sherman's studies encounters immediately the theoretical objection that all these extensive surgical procedures on veins carry a possible high mortality rate from pulmonary embolism.

There hardly seems any solution for this impasse, which is, the incomplete job with a tendency to recurrences but with a low mortality *versus* the more radical and the more definitive job with a greater mortality. A possible prevention of the danger of embolism in the latter group of more extensive procedures might be attempted by adding treatment to prolong the clotting time of the blood so that thrombi would not be allowed to form. If one can predict at all it would seem that the future trend will be toward more careful dissections aiming to eradicate the incompetent perforating vessels, to excise the enormously dilated veins that postoperatively fill up with unpleasant clots. To this someone may venture to add some anticoagulant therapy when this has been safely developed. The problem remains: Can the radical procedures be done more safely than in the past?

### SPECIFIC SUGGESTIONS FOR THE TREATMENT OF VARICOSE VEINS

Current cases requiring treatment cannot wait for the solution of all of the problems. Therefore we

have adopted the following policy for the present. The injection procedure alone is reserved solely for the obliteration of the small subcuticular, spidery "bursts," or the other small superficial varices which are to be treated for cosmetic purposes. Conceivably injections might also be used for the palliative treatment of a chronic varicose ulcer in a patient who for the moment cannot take the time to have the complete surgical procedure carried out on his varicose veins.

All cases of varicose veins without demonstrable incompetent communicating veins, in which there are no contraindications for surgery, are treated by the simplified procedure of high ligation and division of the saphenous vein with retrograde injection. It is emphasized that the high ligation and division with retrograde injection is reserved for the cases that do not show any sign of incompetent communicating vessels below the saphenous opening. The other more radical procedure based upon Sherman's suggestions is applied to those with obvious incompetent communicating veins below the sapheno-femoral junction.

In order to avoid the complication of pulmonary embolus at least two precautions are necessary, and these are: (1) the saphenous ligation is done exactly at the sapheno-femoral junction; (2) the patient with the simple ligation is activated almost immediately, and the one with the more extensive procedure is encouraged to move about the bed and to be out of bed most of the time following the operation. This is at the expense of the optimum treatment of the wounds.

SUMMARY

The present status of the subject of varicose veins has been reviewed briefly. An interesting hiatus in our knowledge of the etiology of varicose veins, having to do with the high proportion of women afflicted, is pointed out. The warning is given not to undertake lightly the surgical treatment of varicose veins in the presence of activity of the phlebitic syndrome.

The application of Sherman's studies on the anatomy of the variations of the veins with reference to surgical procedures on varicose veins is discussed.

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# INTRAVENOUS CLOTTING

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So many recent advances have been made in the study of intravenous clotting that our concept of this condition has undergone considerable changes. The syndrome formerly referred to as *thrombophlebitis* is now differentiated into *thrombophlebitis* and *phlebothrombosis*. Since the outlook and management in these two conditions is entirely different, it seems important therefore to review the subject and to bring out the important distinguishing points of the two types of intravenous clotting, namely: thrombophlebitis and phlebothrombosis.

According to Ochsner and DeBakey, the basic difference is this: The clotting in thrombophlebitis is the result of *injury* to the vascular endothelium from mechanical trauma, bacterial invasion or chemical injury; whereas in phlebothrombosis, the thrombus is a result of *venous stasis* and alterations in the clotting tendency of the blood.

There is also difference in the prognosis: In thrombophlebitis, the clot is firmly adherent to the vein wall and is less likely to become detached as an embolus, while in phlebothrombosis the clot is loosely attached to the vessel wall and is therefore likely to cause embolism. Later, I shall indicate how to tell the two types apart.

Some of the causes of intravenous clotting are well known, others are not so familiar. Predisposing factors include cardiovascular disease, advancing age, seasonal variation, constitutional diathesis, obesity, debility, varicosities, excessive smoking, anemia and foci of infection. The precipitating causes are: trauma, with its consequent blood and vascular changes, and circulatory retardation. Any tissue injury from operative, accidental or puerperal trauma produces absorption of the harmful substances from the injured cells, which in turn cause changes in the blood elements, retarding clotting.

A few additional remarks about these etiological factors will emphasize their importance. As to cardiovascular disease, Storz says that the incidence of postoperative clotting is dependent more upon the condition of the heart and the circulatory system than upon the operation or the disease. The value of prophylactic treatment of heart disease in preventing thromboses was shown by von Jaschke. In a series of operations in which the patients were systematically digitalized, the incidence of thrombosis was cut down one half from a previous non digitalized series. Other clinics have reported results along similar lines.

Advancing age is a factor chiefly because of the presence of cardiovascular disease. The condition is rare in people under forty who have no heart disease. For the same reason, debilitating conditions such as anemias, tuberculosis and general toxemias are also predisposing.

It seems quite clear in many cases that there is a *familial tendency* to clotting. Such people are described as adipose, weak-muscled and pale. If this predisposition is recognized, anticoagulants such as heparin and dicoumarin may be given prophylactically.

*Obese* people are more likely to develop clotting than slender ones. This is shown by figures in many clinics.

Varicose veins definitely predispose to venous thrombosis, due to the stagnation of blood in the dilated veins.

That *smoking* is a factor has not been fully appreciated. Smoking produces vasospasm which in turn produces vascular retardation and so, thrombosis. As a prophylactic measure, it is desirable for patients who are to undergo an extensive operation to refrain from smoking for a number of days before the operation.

*Malignant* disease is another definite predisposing factor. The increased clotting tendency in malignancies is very marked.

To review the causes: All the factors mentioned above lead either to changes in blood constituents or to circulatory retardation and thus cause phlebothrombosis. In thrombophlebitis, on the other hand, the clotting is due to injury of the endothelium by the inflammatory process.

Because clotting is due to circulatory retardation, is probably the reason why clotting usually occurs in the lower extremity, for it is here that the greatest amount of slowing occurs. Movement of venous blood depends upon three factors: (1) The force of transmitted pulsation through the capillaries, (2) the negative pressure within the thorax and (3) contraction of skeletal muscles. The negative pressure within the thorax is definitely less following a laparotomy, because of decreased breathing excursions. Also important is the fact that a patient who is ill usually keeps the lower extremities quiet which eliminates skeletal muscle contraction as a factor in the propulsion of blood.

As mentioned above, clotting usually occurs in the lower extremity. It occurs as well in other regions of the body, but these will be left out of this discussion. The involvement may be either in the deep or superficial veins. Of the deep veins, those in the calf muscles and on the plantar aspect of the foot and the femoral-iliac vessels are most likely affected. The left leg is involved more often and occasionally both legs are involved. There are several reasons why the left vein is involved more frequently than the right. The left iliac vein joins the vena cava at a more acute angle, which tends to produce stasis. The left iliac vein is crossed by the right iliac artery and also the filled rectum and sigmoid exert more pressure on the left side, all of which favors stasis.

Microscopically, in phlebothrombosis there are minimal changes, while in thrombophlebitis there is a perivenous lymphagitis as well as changes in the vein wall itself such as hyperemia, exudation, etc.

In addition, there are differences in the thrombi themselves. In thrombophlebitis, we have what is usually called a *white* thrombus, characterized by deposition of platelets and white cells. In phlebothrombosis, on the other hand, the thrombus is *red* in color due to the high proportion of erythrocytes. The white thrombus is firmly attached to the destroyed vascular endothelium and has little tendency to become detached. On the other hand, the red thrombus is attached only loosely to the vessel and is likely to give rise to pulmonary embolism.

The clinical manifestations of the two types of clotting discussed here are quite different. In thrombophlebitis, there is usually a fever, its height depending upon the severity of the infection. The patient also has *pain* in the region of the involved vein and *swelling* of the affected extremity. The swelling has previously been thought to be due to edema caused by obstruction by the thrombus. However, when ligations of the same vein were done aseptically and no swelling appeared, this explanation seemed inadequate. Ochsner and DeBakey showed clinically and experimentally that this edema is due to severe arteriolar spasm due to impulses carried over the sympathetic nervous system and originating in the thrombophlebitic segment. This work has led to a more rational treatment of thrombophlebitis which shall be discussed presently.

Patients with phlebothrombosis, on the other hand, may have no symptoms at all. They frequently have a feeling of impending disaster, but no pain, no fever, and usually no swelling. It is in this type of patient that on the 8th to 10th day postoperatively, when preparing to get out of bed or while straining at stool, that the dramatic syndrome of pulmonary embolism occurs. Of some importance in phlebothrombosis is an increased pulse rate out of all proportion to temperature elevation.

From the diagnostic standpoint, it is of great importance to determine whether there is tenderness in the involved veins. Since these clots frequently initiate on the soles of the feet, one should squeeze the feet to note tenderness. Tenderness of the calf muscles on compression or by Homans' maneuver (which is dorsiflexion of foot eliciting tenderness in calf muscles or popliteal fossa) is of great significance.

The diagnosis of *thrombophlebitis* is not difficult, but *phlebothrombosis* should be suspected in a patient who shows the signs mentioned above, namely (1) unusually rapid pulse, (2) tenderness of feet or calves. *Phlebography* with the aid of diodrast solution injection can be done to substantiate the diagnosis.

The treatment is primarily one of prophylaxis. Cardiovascular function must be brought to as nearly normal a state as possible. Reduction of weight and correction of anemias is important. Smoking should be prohibited preoperatively. Compression of superficial veins by an Ace bandage is of great prophylactic value. In this way, stagnation of blood is obviated.

One of the most important measures is the avoidance of trauma in surgery because, as previously mentioned, tissue injury increases the coagulability of the blood. Sharp dissection, careful handling of tissues, and careful vessel ligation with only a minimum of tissue tied, are imperative.

Postoperatively, increased viscosity of blood may

be obviated by rehydration and mineralization. Any posture which leads to circulatory retardation should be avoided. This includes the favorite Fowler's position which produces compression of the popliteal vessels by a bend at the knees. The Trendelenburg posture on the other hand favors blood flow. Since contraction of muscles is of greatest importance prophylactically, early movement of the legs, bed bicycling and early ambulation are advised. Many clinics have practically eliminated this complication by allowing their patients up out of bed the first or second day postoperatively. Deep breathing is also of value because it increases the negative pressure. This is to be discouraged, however, if a phlebothrombosis is suspected, as it may dislodge the clot. Where clotting is suspected or anticipated, drugs such as heparin or dicoumarin—anticoagulants—are used. Too much reliance should not be placed on the use of these drugs alone.

Once clotting has occurred, from the standpoint of therapy it is important to differentiate thrombophlebitis from phlebothrombosis.

In thrombophlebitis, the method of therapy most efficacious and based upon the theory of arteriorlar spasm, is blocking of the regional sympathetic ganglia with novocain. This produces vasodilatation by abolishing the vasoconstriction. The disappearance of symptoms with this therapy is dramtic. The relief of pain is immediate and in 90 per cent does not recur. In 10 per cent a second injection is necessary. The edema which ordinarily takes 6-8 weeks to disappear or even months, disappears within 4-10 days. Fever disappears in 2-5 days.

The technic of lumbar sympathetic block is simple and is described as follows: The patient is placed in a lateral position similar to that for spinal tap. Sites of puncture are determined by taking points two fingerbreadths lateral to and level with the spinous process of the 1st, 2nd, 3rd, and 4th lumbar vertebrae. A cutaneous wheal is made. Lumbar puncture needles are introduced at each point until the transverse process is reached. The direction of the needle is now changed either above or below the process and is inserted about 3 cm. beyond that. 5-10 c.c. of 1 per cent novocaine is deposited in each of the 4 spaces. This is repeated daily until the fever disappears.

Radical intervention is *not* necessary in this type of clotting unless suppuration appears at the site of the clot.

The treatment of *phlebothrombosis,* in contradistinction, is always radical. Unless something is done to prevent the clot from getting into the systemic circulation, a tragedy may result. Exposure of the venous system above the area containing the clot is necessary.

The technic for ligation of the femoral vein is as follows: The vessel may be approached by an oblique incision parallel to the inguinal ligament or by a longitudinal incision. The pulsation in the femoral artery is the guide to the vein which lies medial to it. The saphenous opening is demonstrated and the fascia lata is cleared around it. The femoral vein and it branches are now freed and small soft rubber tubings or heavy ligatures are passed about the common femoral above, the superficial femoral below, the profunda behind and the saphenous. The superficial femoral is now incised longitudinally. Bleeding is controlled by traction on the tubes or ligatures. A glass suction tip is inserted and loose clots are sucked out. The vein is then ligated and divided. Patients who have a ligation above the profunda seem to have more edema postoperatively. In such cases, postoperative swelling usually lasts 4-8 weeks—but may last up to a year. The usual postoperative stay is 7-10 days.

To summarize:

1. What was formerly known as thrombophlebitis is now known as phlebothrombosis and thrombophlebitis.

2. In the former condition, the clot is loosely attached to the vessel wall and is likely to be the cause of a pulmonary embolus.

3. The predisposing as well as the precipitating causes are listed.

4. Clinically the two conditions are quite different, dangerous phlebothrombosis is practically asymptomatic except for an unusually rapid pulse localized tenderness and Homans' sign.

5. From the standpoint of treatment, prophylaxis is most important. Where the diagnosis of phlebothrombosis is made, aspiration of thrombus and division of the vein should be done, while thrombophlebitis responds dramatically to sympathetic ganglion block.

# THE MEASUREMENT AND TREATMENT OF STRABISMUS IN CHILDREN

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WHEN YOU listen to how the other fellow does it, you can profit in one of three ways: 1—You may possibly learn something new; 2—you may gain the satisfaction of knowing that someone else works the same way that you do, or 3—you have the elation of finding that your own method, in contrast to the speaker's, is superior. Since I doubt that I have anything new to tell you this afternoon, any profit that you may derive from my remarks will most likely fall under the latter two categories.

In our quest for more perfect results in the treatment of squint, one of the important steps leading up to surgery is the making of the most accurate possible measurement of the deviation. This subject has received considerable discussion in the various postgraduate courses given throughout the country in recent years, but from helping with the American Board Examinations, I have found that many men still rely on methods that I consider not the most accurate. Possibly what I have to say about measurement will be superfluous to this audience.

I believe that we are seeing our squint cases at an earlier age than we used to, and many of us are operating earlier, occasionally under two years of age. This makes it important for us to have some method of estimating the deviation before we are able to utilize the cover test of Duane. After trying every method that I could find in the literature, I am satisfied that the Hirschberg corneal reflex test is the best method for very young children. Probably you are all familiar with this test but briefly, it consists of holding a small flash light directly in front of the child, at about 13 inches, and preferably in front of your own nose. From this position you can observe the reflections of this light in the two corneas: one more or less centered in the fixing eye and the other eccentrically placed on the cornea of the squinting eye. By estimating this displacement, one arrives at an approximate measure of the deviation. The rule is 16 diopters for each millimeter of displacement. It is sufficiently accurate to consider the radius of the cornea as 6 mm. for this. To get your bearings, it may be helpful to measure the distance from the reflex to the limbus with a transparent ruler. With a little practice, this determination can be made very quickly and with fair accuracy. The same measurement can be made for distance but it is difficult to get a small child to fix in the distance and hard for the observer to get into a position to see the corneal reflex. The excursions of the eyes in the six diagnostic directions can usually be achieved with a little patience, to complete the picture of the squint. This will give adequate information, in many cases, to proceed safely with operation. The same method of measurement applies to cases with poor vision in one eye.

The age for the successful utilization of the cover test will vary considerably; occasionally it can be used at 3 but usually not until 4 or even later. There is no doubt in my mind that it is the simplest and most accurate way to measure a deviation and that it gives the fullest picture of the muscle anomaly. I am sure that you have all heard the arguments but I feel that it is so important to become familiar with this test and learn to use it, that I am going to risk boring you by describing it.

In the first place, the only equipment necessary is a set of prisms and if the war makes it impossible to get the square prisms that are most convenient to handle, it is perfectly possible to use the round prisms that come with every set of trial lenses; for the higher powers, use your trial frame and divide the prisms between the two eyes. A small muscle light at approximately 20 feet, is desirable, particularly for children. With the child looking at this light, cover each eye alternately with a card and watch what the eyes do when the cover is shifted. This cover breaks up fusion completely and allows the eye behind it to wander where it will. When the cover is shifted, the eye moves back to take up fixation. Even when slight, this movement can easily

*Presented at the 152nd Annual Meeting, Connecticut State Medical Society, Bridgeport, May 4, 1944*

be detected and indicates the nature of the deviation, either latent or manifest. Placing prisms before the eye, with the apex in the direction that the eye deviated, until the motion is stopped, will give an exact measure of the entire deviation. If the eye turns up or down as well as laterally, both deviations can be measured simultaneously by placing two prisms, with apices in two directions, before the eye. The same measurements are then repeated with the child looking at a small light which he holds against your nose; a flashlight which he holds himself on a specific point holds his attention. The excursion test, carrying the light in the six diagnostic directions, should demonstrate any limitation of motior or secondary over-action of a muscle. More precise information both as to the diagnosis and the amount of the deviation can be obtained by measuring with the prisms in these six positions, but this will depend on the cooperation of the child and is not always possible. The measurements for distance and near should be repeated with glasses fully corecting the refractive error.

In describing the cover test I hope that I have brought out some of its advantages, namely: simplicity; little equipment required; it measures both lateral and vertical deviations at the same time; it measures in different directions of gaze; it gives the fullest, most accurate measure of the deviation and the most complete picture. Its two limitations are that it requires cooperation and central fixation in both eyes.

Turning now to the treatment, I am sure that no one in this audience needs to be impressed with the importance of prescribing glasses that fully correct the hyperopic error, at the earliest possible age, frequently under two years. This will straighten the eyes in enough cases to make it worthy of a trial, unless the refractive error is insignificant. And I believe that the glasses must be worn consistently for a few months before their full value can be determined.

I hope that your opinion as to the use of occlusion to correct amblyopia is equally unanimous. There is no practical test to tell whether an amblyopia is from disuse or caused by some pathology, in a small child. My practice is to occlude the fixing eye continuously for two months. If the amblyopia is from disuse, there will be an improvement in vision. If there is no improvement, it can be assumed that there is a permanent defect. It is not necessary to wait until the child is old enough to have his vision tested, before starting occlusion. If it is a monocular squint, you can assume that the other eye is amblyopic and if after occluding the good eye for two weeks or so, the other one takes up fixation, you can be sure that the vision has improved approximately equal to the other eye. To begin this treatment, you should use constant occlusion and I have had the best results with a firm adhesive dressing, worn day and night. Wearing an occluder for a couple of hours a day may be all right after the vision has been equalized, but even then it is probably better to wear it a day or a week at a time, just to insure that the eye is being used. Some of you may wonder what is the use of all this fuss to bring up the vision when so frequently it slides back again as soon as the treatment is stopped. To be sure, the only guarantee of holding it is to achieve biocular single vision, but my objective is to keep the vision up by repeating the occlusion from time to time, until around school age. It may still slip back a little but I have a theory that if the vision has been brought up to normal in the fifth year, it can always be regained later if needed. Now for one word about the use of atropin for occlusion. It should be apparent that unless the atropin will blur the vision enough to produce a shift in fixation, it will not be effective. This will only be the case in high hyperopia or silght amblyopia and should always be supplemented by pasting paper over the spectacle lens for that eye.

I hesitate to take up the question of exercises because so little positive information about them is available. However, I can tell you that I am not using them for these young squint cases and for the following reasons: Exercises can rarely be utilized under 4 years of age and frequently not until 5 or 6. This may mean waiting 2 or 3 years, while the squint is becoming more firmly fixed and the child is undergoing psychic trauma from the taunts of his playmates. Few of the exercise enthusiasts claim to straighten any but the smallest squints; the exercises are rather to develop binocular vision and fusion, thus insuring a more perfect result. The theory is attractive but in my experience the ends do not justify the means. The exercises should be given 2 or 3 times a week for months or even years; this requires a lot of time from both the child and a parent; it is expensive and it may be a serious nervous strain on the child. Even this might not be too much if we could guarantee a perfect result but exercises even under ideal conditions are not always successful. The parents bring the child to us because the eyes are crooked: they are not worried about binocular single vision. Until we can know pretty

definitely which cases will respond to exercises so that we can give the parents an accurate prediction as to the duration of the treatment and the final result, I do not believe that they are practical and will not use them in my practice.

Once we have the most accurate possible estimation of the eye deviation, and have completed any medical treatment that is indicated, our next problem is to translate our measurements into a surgical procedure that will correct it. I do not have a perfect answer to this final problem. I do not believe that we have perfected our surgical techniques to a point where we can predict our results with certainty. It is particularly hard for any surgeon to tell anyone else just what to do to correct a given deviation. No two of us will do the same operation exactly the same way. For this reason I want to caution you against the tables, in many text-books, that give so many degrees of correction for each millimeter of recession or resection; at best they are only vague guides with which to get started in muscle surgery. You must find out, by careful pre- and postoperative measurements just what effect you obtain from a given operation. But if this is to mean anything, your operative technique must be consistently precise and you must know exactly how much you have shortened or receded a muscle.

There are probably several different operations, and innumerable small variations of technique in each, that will give comparable results in the hands of different surgeons. My methods of doing a resection and a recession are not original with me, nor do I believe that they are necessarily the best. They appeal to me as being logical and simple, and they have given satisfactory results.

The resection operation that I have been using for several years is the one described by Lancaster. The advantages as I see them are briefly these: after the tenotomy, with the muscle held in the clamp, the sutures (2 double-armed oooo 10-day chromic) are placed in the stump, from within. They are then passed through the muscle, again from within. In the interest of precision, the clamp should always be placed at the same distance from the insertion and the distance from the clamp to the sutures should be measured. The muscle is then carried forward by the forceps while the eye is rotated toward the muscle and the two mattress sutures can be tied without tension. Most other methods for the resection utilize the sutures to pull the muscle up, with the danger that they may slip, making the effect uncertain. In Lancaster's operation, the excess of muscle is not excised until the sutures are tied, so that if a suture is cut or broken no harm is done. No unrelated tissue, such as conjunctiva, is interposed between the muscle and the stump as in the Reese operation. The conjunctiva is closed separately so that careful and complete closure is possible.

For the recession, I follow a variation devised by Dunnington. After isolating the muscle on a hook, two single-arm sutures are placed as close as possible to the insertion, leaving space only for the tenotomy. The needles are then passed through the superficial layers of the sclera, a measured distance from the insertion and tied. The two sutures spread out the tendon. Possibly it would be a good plan to lock the sutures on the tendon but this has not seemed to be necessary and I have been reluctant to bury any unnecessary cat-gut. The conjunctiva is closed separately, with the same suture material.

I feel certain that you have shared my experience that the more squint cases you study, the more of them you find complicated by over-action of one or both of the inferior oblique muscles. If these over-actions are equal, on the two sides, and not marked, they can be ignored. But when the up-shoot is apparent, the action of this muscle should be weakened, preferably at the same time that the lateral deviation is corrected. My choice for this is the recession of the inferior oblique at its insertion onto the globe, as advocated recently by White. This operation is particularly well suited to the combined procedure as a tenotomy of the externus is desirable to give the best exposure of the inferior oblique. You have all seen how the insertion of the inferior oblique lies right beneath the external rectus and is frequently closely adherent to it. The inferior oblique is easily hooked and a double-armed suture is placed in it close to its insertion, which is then separated. In placing the suture in the episclera, it is important to maintain the normal line of pull of the muscle. Specific indications as to the amount of recession cannot be given but so far our tendency has been to undercorrect.

It is my practice to put a bandage only on the eye that was operated upon and I usually take it off permanently on the fourth or fifth day. The children leave the hospital on the second or third post-op. day.

In telling you how I handle children with squint and in pointing out a few of the things that seem important to me, I hope that I have been able to bring you another viewpoint for comparison with your own convictions.

# METALLIC FIXATION OF FRACTURES BY THE USE OF MORE RECENT METHODS AND APPLIANCES

## Special Reference to Kirschner Wire, Vitallium Screws, Tantalum Foil and Plates

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EVERYONE knows that broken bones must be kept quiet in order to unite. In considering the matter of how this is to be accomplished, we must have very clear ideas as to what we are talking about. In the first place, it should be noted that any so-called "traction method," such as the Russell traction, employs pillows, slings, stirrups, pulleys, etc., to maintain some definite position of the extremity, which is really a method of splinting even if someone should insist that no splints are being used. Traction methods accomplish more or less (often less) rest of the fractured fragments which, in selected cases like some intertrochanteric fractures of the femur, may be satisfactory in skillful hands. We must remember, however, that most of these methods of traction also employ the bed, which is the fundamental splint, and which may produce more immobilization of the general anatomy than is desirable. Most fractures, we note, require more rest than traction methods afford.

"Immobilization" and "fixation" are technical terms, often used very loosely. However, they have exact meanings which should be kept in mind. The term, *immobilization*, implies keeping the fracture still by also putting at rest the neighboring joints. This is brought about by the use of some form of *external splinting* which may be simple recumbency in the bed, or may employ frames, plaster of Paris, metal splints or braces.

The term, *fixation*, designates some method of fastening in place the fragments of the broken bone so that the adjacent joints may be allowed a considerable range of motion with corresponding exercise of the neighboring muscles. Implicit in this definition is the use of some form of apparatus to accomplish the purpose. Of such apparatus there are two fundamental types. First, we may apply directly to the fractured bone, grafts, wires, nails, screws, or plates, which are to remain permanently as a part of the anatomy. For these methods, the general term, *permanent fixation*, may well be used. Second, we may transfix the bone, or insert into it, wires, nails, or screws, which project beyond the skin, temporarily installed, to aid in reduction and to maintain it until union has taken place, whereupon the apparatus is removed. For these methods, the term, *temporary fixation*, seems appropriate.

Internal fixation of fractures with wire began in 1775, and nailing of fractured hips has been done since 1878, so that permanent fixation of fractures by the use of metal as a surgical method is getting along in years. Between 1905-10, Lane published the use of his silver-coated plates and screws, and also the value of silver wire for fixation. Since then, many studies have been made on the tolerance of various metals by the tissues of the body, and modern metallurgy has furnished numerous alloys to be tried out in such tests. At present, the matter is pretty well sifted down to three basic metals and two alloys, all of which are well tolerated in the body.

The basic metals are gold, silver, and tantalum. Gold, which has been such a boon to dentistry for so many years, is giving way more and more, in that technic, to fine quality ceramics and the new plastic materials. Gold tubes have served well to drain antrums through tooth sockets. Silver wire is cheap, easily worked, and perfectly tolerated. In the larger sizes (16 and 14 guage), it is of very satisfactory strength for fractures of the olecranon and patella and these large sizes will not cut through the bone under tension, as the fine steel wires, now in such favor, often do. In stellate fractures of the patella it is quite easy to weave this heavy silver wire through the aponeurosis around all the fragments, twist it down and bury the end at the upper pole

*Presented at the Twentieth Clinical Congress of the Connecticut State Medical Society, New Haven, September 29, 1944*

Some surgeons are so strong that they twist wires until they break. This is wholly unnecessary. Firm tension on each end of the wire, starting the twist close to the bone, is all that is required. This method allows the patient to walk in 6-7 days and often he is back at work in 4-6 weeks. Tantalum, the newest of our basic metals, is very expensive. It cannot be cast into molds. It is tough, ductile and malleable, and hence can be made into fine wires and very thin sheets. The thin sheets will probably have great usefulness for the repair of large defects of the abdominal wall and in our work, may turn out to be valuable in arthroplasties. The tendency of these sheets to form wrinkles when fitted over bone ends may interfere with smooth movement of the surfaces. Probably, later, the sheets will be furnished in pouch or baglike shapes adapted to the various arthroplasties. These three metals, gold, silver, and tantalum are spoken of as "basic," because they are pure elemental metals not mixed or alloyed with others.

Only two alloys are of importance to the fracture surgeon, vitallium and what is known as 18-8 stainless steel. Vitallium,[1,2] an alloy of cobalt, chromium, and molybdenum, has come into great prominence because it is without electrolytic action and does not corrode in the tissues. This is a very valuable quality, but it is counterbalanced by the fact that the metal is very brittle. It cannot be machined. Screws made from it must be cast in molds and are apt to break if side strains come upon them when used. Its physical properties are the exact opposite of those of tantalum, for vitallium is not ductile nor malleable. Castings of vitallium may well serve to cover skull defects or to replace a lost head of the humerus. At present, vitallium cups seem to be the best for arthroplasty of the hip. Plastic cups, so far, have only the advantage of x-ray permeability and they are still in the experimental stage. My personal belief is, that, before long, we will have tantalum cups, about a sixty-fourth of an inch thick, with more or less of a skirt on them, which skirt we can pinch up with a pair of pliers into two or three tucks to tighten it about the neck of the femur. For the manufacturer to form such cups over a suitable stake should present no problem with such a malleable metal. Probably they will cost $15 or $20 each, but they will be worth it.

The 18-8 stainless steel contains 18 per cent chromium and 8 per cent nickle with 2-3 per cent of molybdenum, which helps to prevent corrosion. This steel is ductile, has high tensile strength and can be machined. Kirschner wires, transfixion pins, plates, and screws (with machined threads) of all types are made of this material. Quite different from vitallium, screws and pins of this metal will bend before they will break. This is a great advantage to those surgeons who are very strong, or who are in haste about their work. This metal is sufficiently inert in the tissues so that, by itself, there will be no electrolytic action or corrosion. In a fracture such as the very lower end of the humerus, two short Kirschner wires, placed obliquely through, or in the dense ligaments close to the epicondyles and directed upward into the shaft of the bone, will produce perfect fixation. On withdrawing the wires three weeks later, it may be noticed that one of them slips out more easily than the other and seems to show an extremely thin, dark coating on its surface.

The explanation of this is undoubtedly the fact that 18-8 stainless steel varies slightly in the exact proportions of its ingredients from one batch to another. There has to be a slight latitude of the proportions. Chromium may vary from 17 per cent to 23 per cent, and the other metals proportionately. A large number of wires or screws secured at one time probably will be from the same batch and so would be less likely to produce any electrolytic action. In any hospital, screws and wires, from various supply houses, accumulate over the years. To the nurses, bone screws are just screws. They have no idea that the shapes of screw heads vary with the plates of different manufacturers, or that the quality of the metal makes a difference.

One of the greatest difficulties we work under is the lack of standardization of equipment. One manufacturer makes a very fine screw driver, but it will only hold his own type of screws. Smith-Petersen nails sometimes must be removed. I once pried one out by main strength, working forty minutes. I had three different makes of extractors, none of which would fit the thread in this nail. It is a travesty of human intelligence, in this day and age, that the manufacturers do not get together and standardize such things.

Why use Smith-Petersen nails? Moore pins are easy to insert, just as effective, easily removed (with any pair of pliers), cheap, and *harmless*. Even if you push one through the head, it only lifts up a little trap-door of cartilage, which drops in place on pulling back the nail. If you have to pull them out and put them back several times to get a satisfactory

arrangement, the extra holes serve to let in more blood supply, which is an advantage. With a fracture of the neck, and comminution through the trochanters, with the great trochanter split in the coronal plane, the Smith-Petersen nail cannot be used. Moore pins, however, will meet this situation. All the tools to put them in or remove them may be bought in any hardware store for less than ten dollars. Why must every appliance we use be something "especially made"?

Blount[4] and Moore[5] have each developed a special hip nail provided with a plate, with holes for screws, to extend down the side of the femoral shaft. These nail-plate combinations are excellent for intertrochanteric fractures, although they were first developed for securing high osteotomies of the femur.

An oblique fracture entering a joint, such as fracture of one condyle of the humerus, lends itself to open reduction and permanent fixation by means of one or two vitallium, or 18-8 stainless steel screws. An extremely important point comes up in connection with this application of screws. The screws must have tap points so as to cut a thread for themselves in the cortex of the shaft. This requires that the hole drilled in this cortex be smaller than the screw by nearly twice the depth of the thread. In the cortex of the fragment, however, the hole must be large enough to allow the screw to pass through easily. If both holes are bored small, the screw will cut a thread in the first cortex, but will not thread into the second cortex without forcing the fragments apart.

It is easier and quicker to put in one or two screws in this way than to bore holes and pass wires through them. Fastening fragments with the fine double steel wires is often satisfactory. In the long bones, the wires usually should be inserted in two planes of space, for a single loop holds very firmly in one direction, but in the other plane, it is apt to act as a hinge allowing displacement.

This point about fixation of long bone fractures in two planes[3] is particularly important in the case of the femur, where a long and heavy extremity puts great strain on any form of apparatus which is used. Often it is best to supplement fixation of the femur by temporary immobilization in a cast or splint. Multiple fractures of the femur, or a comminution three or four inches long may be satisfactorily treated by plating.

Probably all the old plates of Lane and Sherman types will be discarded soon in favor of the new plate developed by Townsend & Gilfillen.[6] This plate comes in two sizes, large and small. Each size is furnished in several convenient lengths, but you need buy only the longest, for they are thin and can be cut off with a tin shears to suit the situation. They are slightly springy, and in cross section have the shape of the letter "M," so that they only touch the bone along each edge and at the middle where the screws draw them down tightly. As the plates will nest over each other, two can be applied together where greater stiffness is required. The screw holes are three-eighth inch slots which makes them adaptable to shingling one plate onto another for the whole length of the femur, if you wish. They are of 18-8 stainless steel, and the screws for them are beautifully made. Just imagine a plate which you can make longer or shorter at the operation! It is a real satisfaction just to think about them. I have in expectation the use of one or two of these plates on the side of the femur in combination with Moore pins inserted through the plate, for a bad trochanteric comminution.

There is a plate being produced in tantalum, which has slots instead of round holes for screws, and doubtless it will be very satisfactory.

So much for permanent fixation with metal. We have left to consider temporary fixation.

In the first place, ice-tongs, Kirschner wires, or Steinman pins with stirrups attached to them, are traction devices. They become temporary fixations only when they are incorporated in plaster of Paris, which, if it immobilizes joints, makes a combination of fixation and immobilization. Such a combination may be very useful. The traction stirrup may be quite essential to accomplish reduction, whereupon to incorporate the device in plaster turns it into fixation or immobilization, thus avoiding further procedures.

A number of years ago, some clever machines came on the market which have been quite useful, particularly with long comminutions or multiple fractures of the leg. They depend upon transfixing the tibia near each end with steel rods of five-thirty-seconds, or three-sixteenths inch diameter, the rods being clamped, at their ends, in a machine furnishing traction and adjustments in the three planes of space. After reduction, the two rods and intervening leg are incorporated in plaster. This machine is very satisfactory, and newer apparatus, such as the Roger Anderson,[7] Stader,[8] or Haynes,[9] devices have no advantage over it in selected cases where there are

no large wounds.

In 1937, Stader[8] developed his apparatus for the reduction and fixation of fractures, which worked so well in dogs that by 1939, it was adapted for the general use of fracture surgeons. It is somewhat spectacular and hence, has had much publicity. Most of the instrument makers have produced their own, or some surgeon's, modification of the Stader device, which, itself, has been improved.

These various machines are primarily intended for the reduction of simple fractures of the long bones without the necessity of open reduction. Two or three pins are inserted into each fragment at some distance from the fracture site. The pins in each fragment are clamped solidly together, and the two clamps are connected by an adjustable screw arrangement which controls the motions necessary in effecting reduction, and which is then solidly clamped to maintain the position.

At present, the Roger Anderson[7] apparatus is the most elaborate one. The Stader[8] is the simplest. The Haynes[9] is similar to the Stader, but its clamps provide for three pins in each fragment instead of two. In the use of this method, it is necessary to place the pins in the bone in such positions that a minimum of damage to the soft parts will be combined with the best leverage and mechanical advantage. To this end, very helpful ideas are to be found in an article by Junkin,[10] in last May number of Industrial Medicine.

If open reduction is decided upon, any one of these machines can be used with it to maintain the position. For this purpose, however, it is very convenient to place four or more long screws in the bone so that they will project through the operative incision, fastening them externally in a solid clamp. In 1939, I had such a clamp made up which has proved very useful, especially with transverse fractures. About this, I never have troubled to write an article.

In 1943, Clayton[11] developed a square rod of fibre, or plastic, pierced by a row of holes through which pins may be inserted into the bone. Each pin can be locked in the bar by a set screw. This device is so simple that it is sure to be popular for fixation of the fragments at open reduction. Its action is like that of a Lane plate, except that the screws project and the plate is outside the skin.

When we are confronted by a displaced, simple fracture in the shaft of a bone, we must decide whether we will do an open reduction or use a Stader type of apparatus. There are several points in favor of open reduction. Interposition of soft parts is of very common occurrence. A periosteal sleeve, cuff, or band may become caught; the fish-hook-like point of a fragment may catch and draw in a muscular fasciculus, or the rough end may grind up and hold a pad of muscle cells. At open reduction, one can clean out such tissue, place the fragments together accurately and carry out permanent or temporary fixation with the fracture in full view. Such work requires less skill on the part of the surgeon and it is definitive.

It may be argued that open reduction converts a simple fracture into a compound one with possible infection. We are not as afraid of infection as we were a few years ago; nevertheless, it is a healthy fear. If the alternative to open reduction is to use a Stader type machine, please realize that a compound fracture is a bone injury connected by a wound with the external world. When you insert four pins in the fragments to set a simple fracture, you are making four compound fractures to do it. You may consider it an axiom that there is no such thing as the treatment of fractures by a fixation method in the absence of one or more compound fractures.

In the heavier bones, fractured obliquely, where the action of muscles easily causes displacement, a tap pointed screw fixed in the deep cortex and bearing two nuts, to hold down the superficial cortex, is easy to install, and the open operation assures perfect reduction with a 100 per cent result. At most hardware stores, screws of $\frac{3}{16}$ inch diameter and up to five inches long can be found which are plated with cadmium. Tap points can be made on them by cutting three grooves with a fine file. Although the filing removes some of the cadmium, they are tolerated in the tissues for as long as three months with no apparent change on careful inspection under a lens. They cost less than five cents each, so there is no money in them for the instrument makers. This is the only conceivable reason why they are not in universal use by fracture surgeons.

In closing, just a word about simple methods of removable fixation. In the early part of this paper, I mentioned two short Kirschner wires, through the dense ligaments close to the epicondyles, obliquely upward into the shaft of the humerus. Two or three straight wires are all that is necessary to fix many fractures, such as oblique ones of radius and ulna, metacarpals and phalanges. It is necessary to keep

the projecting ends well buried in sterile dressings. They may be pulled out in three weeks as easily as skin sutures. This is far better than to put Lane plates on the metacarpals, or on the ulna, as has been advocated in the past. On superficial bones, just under the skin, is no place for metal plates or projecting screw heads.

The conclusion of the whole matter is that we must keep all the various methods in mind and, in each case, select the simplest one that will be effective.

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# WHAT IS THE MATTER WITH THE PATIENT WHO IS ALWAYS TIRED?

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I SUPPOSE one who has been interested most of his life in digestive diseases ought to be talking about some gastro-intestinal problem, but actually one in four or five of the patients I see complains mainly of fatigue. These persons are tired out, they have no pep, they have to drive themselves to work, and many think that if I would only go over them and find something wrong with stomach, or bowel, or liver, or something, I could fix them up and make them happy again.

A woman will say she is dragging around, unhappy because she cannot go out with her husband; she cannot be a good pal for him, and cannot be a good mother for her children. A young woman, perhaps a school teacher, is so tired that on Saturday she has to go to bed and stay there through much of Sunday; she has to live the life of a hermit; she cannot go out in the evening and be fit to work the next day. All such people want to be made stronger, and they hope desperately that I will find some focal cause for their trouble, something that I can tinker at or cut out. Unfortunately, many of us doctors have the same hope; we too have the idea that if we would examine thoroughly enough we would always find a focal cause for the disability, and in attempting to do this, and to satisfy the patient, we often keep grasping at diagnostic straws.

Every day I see tired persons who have been through several overhaulings and have been told that the cause of their troubles has been found in a

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dropped stomach, or a spastic colon, or gastritis, but usually these diagnoses have failed to help the situation and they look to me like placebos. Sometimes, of course, we physicians find something that is definitely wrong, like amebas in the stool, but even then we will not have uncovered the "cause," as shown by the fact that after the parasites are all killed with drugs the patient goes on just as miserable as he or she was before. As I say, the amebas were parasites and it was good to get rid of them, but they were doing the patient about as much harm as so many fleas. There were not enough of them, and they were not causing the symptoms complained of.

Often we explore the abdomen and take out an appendix, or maybe a gallbladder that empties a little slowly; we take out teeth and tonsils, we give a lot of "shots," and what happens? The patient goes to another clinic and gets overhauled all over again. She pays another good sized fee, she gets another placebo of diagnosis, and she has some treatment for this. Later she goes to another clinic and all is done over again, regardless of the fact that most of these persons can ill afford the great expense, and most physicians can ill afford to waste the time. With the best of intentions, we of the medical profession are evidently giving many of our tired patients a raw deal; we are not giving them much for their money, and worse yet, too often in our desperate efforts to help them, we hurt them. Whenever we perform a futile operation on some nervous, frail little woman, who can ill afford to pay even the hospital expenses, we have not practiced good medicine.

### LESION NOT CAUSE OF FATIGUE

Although each year I examine hundreds of these tired people, and have made a life long study of their problems, I must admit that I seldom can find any focal cause for their distresses. I just cannot do it, even with all the fine laboratory and roentgenologic and other facilities that are at my disposal. And oftentimes, when I do find a condition which might be an indication for surgical intervention I do not want to advise it because I am so sure that the symptoms are not due to the condition and that operative treatment will not make the person well.

The other day I saw a woman with a myomatous uterus which she thought was causing all of her ill health and abdominal discomfort. It may well have had some part in doing this, but I doubt now if I would have let her undergo a hysterectomy when I did if I had learned sooner that her husband had recently taken to drinking so heavily that he was facing dismissal from his position, and utter ruin. No wonder the poor wife, wrestling night after night with this problem, was tired out and unable to rest or sleep.

I could tell innumerable such stories to show how often the lesion found is not the cause of the fatigue. In many cases I think most of you would agree with me, after reviewing the record, that the diagnosis that the tired person came with was not significant; the finding may have been all right, but it was not causing the illness and it could not explain all the symptoms.

### EXAMINATION NOT NECESSARY

Commonly, when one of these nervous, tired persons comes in, asking for an extensive overhauling and hoping desperately that at last I am going to find the cause of her trouble, I rather hate to start examining her; I would rather start preparing her for the disappointment which I am pretty sure will come at the end of the study. A physician said to me a few minutes ago, "I wish you would talk to us on the problem of dismissing a 'neuro;' of telling her that she is a 'neuro' and getting away with it; of satisfying her, of getting her to mend her ways, and of keeping her from going straight off to some one else for another examination." Yes, that is one of my biggest problems. Many times I say to these people, "I wish you hadn't come. If only I had seen you in your home town and had talked with you and your wise old family doctor for five minutes, I would have said, 'Your doctors here have examined you well. They have told you that they cannot find anything significant; they have told you that you are chronically frail and ailing like your mother before you. I think they are right; and under the circumstances you must not expect me to work any miracles of healing for you. Why now waste more money on a repetition of all the old tests?' " But these people usually come anyway. They say, "Go ahead and give me a more thorough examination than I ever had before. If you'll only look hard enough and long enough you'll find the cause of my trouble."

I often wish they would give me credit for knowing something about disease and sick people. As I often say, "For thirty-five years I've been studying people like you every day, and surely, by now, I ought to know something about you. I ought to be able to recognize you and your troubles at a glance—

I do, and this problem of yours is nothing new or puzzling to me."

We physicians can have the abdomens of these people explored surgically without finding anything significantly wrong. I remember a man who for twelve years had what appeared to be a psychoneurotic pain in the right upper quadrant of his abdomen. Every year he came back and insisted upon having another examination. Finally he talked a surgeon into performing an exploratory operation, and nothing was found. My assistant said, "Probably the surgeon missed the cause." But eventually the man died of a stroke, and when a complete and careful necropsy was performed, again, no cause could be found for the pain. Actually there should be many types of pain for which we cannot hope to find any macroscopic cause. I think the pain is real, but the cause will never be seen with the naked eye. It may not be in the place where the hurt is; often, probably, it is up in the brain, and the distress is referred out to the periphery.

### CHARACTERISTICS OF FATIGUE OF PSYCHIC ORIGIN

Often one can tell right off that a person's fatigue is due purely to a nervous inheritance. Characteristically, this type of distress is present in the morning; the patient wakes with it and it wears off gradually in the late afternoon. Particularly when a person has a neurotic ancestry, there may be days when he will wake feeling so depressed and miserable that he will wonder how he can find strength to get up and face the day. About three or four o'clock in the afternoon he will begin to feel better, and about ten o'clock at night he may feel like "going places." Obviously, such fatigue is not due to a hard day's work. If it were, it would most likely come at night and would not be such a bruising and punishing type of fatigue. Significant is the fact that in many instances the woman with the terrible type of morning fatigue has no work to make her tired.

Sometimes, in trying to get these patients to see that just from their story and appearance I should know much about them and their disease, I say, "Suppose we were to hear a child cough in a particularly harsh and brassy way, and then whoop and vomit. Couldn't you make the diagnosis?"

"Surely," says a mother of several children, "whooping cough."

"Correct, and you wouldn't feel then that you had to take the child's sputum to the laboratory for the isolation of the bacillus of pertussis, and you wouldn't need to roentgenograph its lungs; you would just know it had whooping cough." Well, when a frail little woman comes in, perhaps with a history of five abdominal operations, none of which did much good, and many complaints of fatigue, aches and pains everywhere, dysmenorrhea, and what not, I do not have much desire to examine her. I have been in the game long enough to know that I am not going to work any miracles for her. Even if I were to find a tumor as big as a child's head, and remove it, I would not work a cure.

### PSYCHOPATHIC INHERITANCE

Often the person with painful fatigue has a bad psychic inheritance. To illustrate: One day I saw, in consultation, a woman forty-five years of age who had the very distressing type of morning fatigue. She had been examined many times by competent men, but nothing significant had been found. She had a good husband, good servants, no overwork, and no cause for unhappiness or strain. I asked just one question: "Which of your near relatives had a bad nervous breakdown?"

She said, "My mother went insane when I was born."

Now, to my way of thinking, this fact explained everything. Her distressing fatigue represented a mild equivalent of her mother's melancholia. I feel sure of it because I have heard this story and seen this association so many times.

Some of you may ask, "But can't you find a history of insanity in almost any family?" No, I cannot find it in the families of most sensible healthy people, but I can find it commonly in the families of the patients with constitutional inadequacy and a pathologic type of fatigue. To be true, insane ancestry must be common because insanity is so common. There probably is a child being born right now in this city, and do you know what its chances are of being committed some day to a state asylum for the insane, the feeble-minded, or the epileptic? The chances are one in nineteen! Think now of the added number of incompetent persons who are cared for in homes, constituting a terrible problem to their relatives, and think of the number of queer relatives each one has, all slightly tarred by this same brush. It is one of the biggest problems facing civilization today.

### RELATIVES OF THE INSANE

One of the commonest diagnoses that I make in the office every day is "relative of the insane." Some

of you may think it a bit queer, but really it is a most helpful and instructive diagnosis. Often it tells me all I need to know about the etiology of a bad hypochrondriasis or psychoneurosis in a person who would like to take up all of my day with a recital of his symptoms.

### CONSTITUTIONAL INADEQUACY

Many of the tired people I see each day are constitutionally inadequate. I think they will always be somewhat frail and sickly. They cannot be made over. When they say to me, "Surely there must be some way in which I can be cured," I reply, "Yes, but the only way I know of would be to begin with a different set of grandparents."

Some doctors say, "Do you mean to tell me that you tell patients that they are hopelessly inadequate? Isn't that terribly discouraging?"

Yes, but often I soften the blow and get them to see what I mean by admitting that to some extent I, too, am constitutionally inadequate. I could not earn my living as a prize fighter or a wrestler. I found once that I could not even stand the long hours and loss of sleep that a busy general practitioner has to endure day after day. I tried it, and found that I could not "stand the gaff;" I had to become an internist who could go home at 5:30. I do not tell these people that they must be a failure in life; what I ask is that they do as I did, and try to find a job within their means of strength. I ask also that they learn to hoard their energies and not to fritter them away on emotional debauches, as so many people do.

### OTHER CAUSES OF FATIGUE

Many tired women are tired because they are so unhappy and so full of worries. Many are unhappily married; perhaps with an alcoholic, or a gambler, or a chaser, or just an inarticulate person for a husband. Many cannot get a divorce because of children or financial responsibilities or frail health. We physicians must get these stories and must help these poor women to adjust to their problems as best they can. Sometimes they regain their health when they are made to see that they just cannot get out of their bed, no matter how unhappy it is, and hence they had better stop thinking of divorce and settle down to make a better go of marriage.

If a patient who comes complaining of fatigue never was worth the powder to blow him up, if he never amounted to a hill of beans, and if he comes of a "poor trash" tribe, most of whom never stuck to a job, I am not so concerned over the diagnosis, but still I am willing to give the man one good examination. A "neuro" *can* have organic disease. But if a man who has always worked hard and felt well suddenly starts to crack, then I want to go over him most carefully and I want to keep going over him until I am satisfied that there is nothing wrong besides overwork.

In such cases a test that helps me much is the estimation of the blood sedimentation rate. Many a time I have had a patient referred to me with the diagnosis of a neurosis, and perhaps at first glance have been much inclined to agree, but when the laboratory reported a sedimentation rate of perhaps 75 or 100 mm. in an hour (Westergren), I settled down to make a most careful examination. In all but a few such cases I have been able to find a serious lesion. In puzzling cases of this type I often order a liver function test, and if the report comes back "dye retention grade 3 or 4" I suspect that the liver is full of metastatic nodules, and then I have the roentgenologist and proctologist study the bowel with the greatest care.

In young people, of course, I look for tuberculosis, and I always have a film made of the chest. Sometimes a college student who has been doing well in his studies, suddenly, after having had one or two vomiting spells or a bad stomachache, will become tired and "pepless" and unable to work. Sometimes, then, it will be found that he has a smouldering appendicitis.

### HYPERTENSION BEGINS IN YOUTH

Hypertension usually begins in youth and often makes the victim a bit tired and worried about his health. Hyperthyroidism, hypothyroidism and heart disease are less common causes for a fatigue state. Often an attack of influenza will leave the patient tired for weeks or months, especially, perhaps, if there has been an encephalitic type of virus mixed up with it. A tendency to migraine will oftentimes go with a fatiguue state.

In my opinion brucellosis is now a poor diagnosis to make. I see many persons with this diagnosis but I can rarely confirm it. Almost every patient who has come to me with this diagnosis has looked to me more like an ordinary "neuro" with ocasionally an afternoon temperature of 99.5 F. I think this temperature is normal for most nervous women. In cases of suspected brucellosis I look at the spleen with the roentgen ray, and when I find it small, I

seriously doubt the diagnosis. I also get a blood sedimentation rate and when it is under 10 mm. in an hour, I cannot believe that the patient has any smouldering infection.

### LITTLE STREAKS THAT GO UNRECOGNIZED

One of the common causes of nervous breaks in older people is a small stroke which has not been big enough to affect the centers for an arm or a leg. Just think of the thousands of places in the brain where a small thrombosis can occur, just big enough to produce a dizzy spell, a little mental confusion, or a few symptoms of bulbar involvement. Some of these little strokes take away all the patient's joy in life, and perhaps the ability ever to work again.

### NERVOUS BREAKDOWNS

Many of the people who come to me with complaints of indigestion really have a nervous breakdown, but they do not tell their history in such a way as to make this apparent. How does one recognize a nervous break? Only by asking a few essential questions. Curiously, able young assistants usually fail to find out the most important thing about a patient, namely, that he has not worked for one or more years. And, if they learn this, many do not think to ask why he does not work. If they had, he would probably have said, "I just can't face people. If I were to try to talk to a customer I would get jittery and have to excuse myself." Very helpful is the discovery that these people cannot read. By way of explanation, they say they are not interested enough, or the letters run together, or they forget a paragraph as soon as it is read. Often such a person cannot stand even listening to the radio, or going to a movie. At a movie he soon gets tense and has to go out. Some get overly emotional, and cry. They cannot make decisions at the office, and their work suffers. Usually they cannot sleep well at night. They are irritable and "fly off the handle" easily. Any person with such symptoms has, primarily, a nervous breakdown; his brain isn't working right.

The next question is: Why has he a nervous break? Was it caused by overwork, strain, worry, sorrow, insomnia, several operations, an automobile accident, or an attack of influenza? If so, and if the patient has a sane ancestry, his breakdown will probably be easily curable. The most dangerous type of nervous break is the one that comes out of a clear sky without any apparent cause in a person who has insane ancestry. Guard your prognosis in that type of case. Guard it also when, in the case of an older person, the break followed some sudden attack which may well have been due to a little stroke. Guard it when there is a history suggesting an attack of encephalitis. Too often the story of an attack of mild encephalitis is not drawn out by the many physicians who see the patient in later years, and so he gets treated for indigestion.

### SUMMARY

Let us physicians not be so determined always to find an organic cause in the abdomen or thorax for a patient's sense of fatigue. Let us look for it oftenest in a tired brain or in a brain handicapped by poor nervous heredity. Let us constantly be on the watch for the symptoms of a nervous breakdown, and when such a break is recognized, let us find out why it came.

## *EVERY MEMBER'S OPPORTUNITY*

The Trustees of the Building Fund, in their early formative days, had visions of a program which would have demanded a much larger fund than the plan which we have placed before you.

Your response to our letter soliciting a pledge for this project has been met with hearty response from many of the members of the Society. The drawing of a building which went with the first letter was an ideal, suggesting somewhat the character of that for which we are striving. At present no definite location or program for building has been decided upon. Any building program at the present time is not allowed and we must wait for the end of the hostilities.

In thinking of the future we must consider the problems which confront the State Office and its needs as to space for the office personnel, committee meetings, conference room, storage space and many minor needs and make haste slowly, preparing wisely for the future.

The entire membership received the first letter outlining our project and from that we received generous response. A second reminder went to those from whom no pledge had been received. The reaction was very gratifying. Recently a third stimulant found its way to those who were still thinking "I must send in my pledge card."

The Board of Trustees are very grateful and appreciative of your loyal and generous support. With this confidence we, as a Board, can carry on and our goal of $50,000 should soon be an accomplished fact.

James Douglas Gold, *Chairman*,
*Trustees of Building Fund*

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*Owned and Published Monthly by The Connecticut State Medical Society*



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# EDITORIALS

## A Responsibility of Medicine

Under the title "Rehabilitation Service Looks Ahead," Edward P. Chester, Director of Rehabilitation Service, State Department of Education and a member of the Connecticut Reemployment Commission has recently presented some pertinent facts in which Medicine must take a particular interest and which cannot be ignored. Mr. Chester points out that while rehabilitation of the veteran disabled as a result of war service is the responsibility of the Federal Government, the rehabilitation of the disabled civilian is the responsibility of the State. Included in this latter group are veterans not eligible for the Federal program, merchant seamen, displaced war workers, workers injured in the course of employment, persons incurring disability as the result of any other accident or through disease, and those who, because of birth injuries, are handicapped from the very start of life. It has been estimated that the number of this civilian group must greatly outnumber that of the veteran group: 8,500,000 of the former against 1,500,000 of the latter. This indicates, says this author, that State facilities for civilian rehabilitation should be developed even beyond that established by the Federal Government, and included in such rehabilitation facilities are diagnostic services, which include physical and mental appraisal, and also occupational diagnosis, which will determine the extent of readjustment required. It must not be forgotten that at the present time, under the pressure of the war effort, many workers are employed whose impairments have been "waived" by Industry and who, when the program becomes less urgent, should wish to improve their health and vocational fitness.

In all this it is apparent that the physician will play a major role and that those who are planning so extensively for rehabilitation will look to the medical profession for substantial aid. The great changes in the relationships of Society which we are now witnessing, no doubt accelerated by the war, involve important and perhaps far reaching changes in

certain methods of medical practice. For some of these Medicine itself will be in large part responsible, for physicians have emphasized for a long time the great value of prophylactic procedures. As a profession we must, therefore, through organization be prepared to meet all proper demands for the medical needs of Society. In considering such organization and such demands we should not forget the admonition of the ancient prophet that, "They have sown the wind and they shall reap the whirlwind."

## The University of Connecticut Looks Ahead

"In this prosperous and progressive area which has produced wealth and culture at so high a level, a State University, even though small, must maintain a high standard of quality to be of significance and value." This statement from the recent report of the Plans of the Board of Trustees for Postwar Development at the University of Connecticut shows that this group of our citizens are clearly aware of their responsibilities in connection with our State Education program. Following the war, in addition to demands from high school graduating classes, will be those of returning war veterans and young women and men who have been employed in defense industries who will wish for further education. With these latter individuals in mind, the Trustees of our State University have offered a new service to veterans, industrial workers, agricultural workers, and to general students who wish specialized semiprofessional or technical training on a postsecondary school level. This service is embodied in the Institute of General and Applied Arts and Sciences. Courses in the Institute will be offered at the University and at extension centers elsewhere in the State.

In the field of Adult Education not only is it planned to strengthen and extend the Agricultural Extension Program for farm and rural people, but to make available similar services for other groups in manufacturing, business, and professional fields. It is also emphasized that the University is in a strategic position to assist in the training of municipal, state and town officials and employees, and suggested that facilities should be maintained for the training of food inspectors, milk inspectors, sanitary workers, water superintendents, firemen, policemen, assessors, clerks, selectmen and town finance officials. A program is also to be provided for the presentation and discussion of Industrial and Labor Relations, to be developed and administered by the Institute of Labor and Management Relations.

These are just some of the postwar plans in which President Jorgenson and his associates are engaging themselves for the future development of our State University. The function of state education in America had its beginnings in public education itself, which dates from the earliest settlements in colonial America. At that time such education was, and still is, considered as a prerequisite to a democratic way of life.

The physicians of Connecticut have a natural pride in these fine developments in our educational system, not only because of their valued citizenship, but also because one of their number, Dr. Samuel W. Gold, the father of our own Dr. James D. Gold, was the chief influence in the founding of the institution which has become our State University.

In summary, it has been said, "Men and women responsible for the University of Connecticut—trustees, presidents, and faculty—have built well its foundations in an effort to carry out the term of its charter—The Land-Grant Act. The postwar program which has been outlined offers real opportunities for service in the realm of higher education. It demands original research and creative scholarship and involves constructive teaching and inspiring leadership. It is a program such as can make the University of Connecticut one of the leading educational institutions in this country."

## The Campaign for Cancer Funds

The Connecticut Cancer Society will join with the American Cancer Society in its campaign this year to raise a large fund, the money to be used for cancer control work and to enlarge and improve available services. This means that the Connecticut group, in conjunction with National, will launch the most ambitious program yet attempted in connection with prevention, diagnosis, and treatment of cancer.

The Connecticut group has always conducted its own vigorous campaign during the month of April and through its educational work has done a great deal to make the state "cancer conscious." This campaign will go along this year with the big national drive. Eric A. Johnston, president of the United States Chamber of Commerce, is the chairman of the Executive Council of the American Cancer Society and national chairman of the fund-

raising campaign. He has large funds and a large staff at his disposal and a big publicity program will be launched through various mediums all over the country.

With National equipped as never before to carry on a successful campaign the Connecticut Cancer Society will profit by the countrywide program and hopes to multiply by five its state membership and quota. Assuming that the national campaign will reach the desired goal, Connecticut, always among the forward-looking states on the subject of cancer control, will have sufficient funds to increase the educational program, to use for laboratory research, to set up detection clinics and to set up any additional facilities that may be necessary to further this work.

## Dr. Anderson Emphasizes Need For Research in Dental Field

Dr. B. C. Anderson, associate professor of surgery, Yale School of Medicine, testifying before the Senate Subcommittee on War Time Health and Education, spoke in behalf of research in the dental field. He urged that there is much need for research in the solution of our general dental problems. He said we should have the courage to take the experimental approach toward dental education by encouraging centers for testing proposed progressive education, by taking the same attitude toward the organization of clinics, especially for school children, and by encouraging research in every dental educational institution in the country. This should be particularly developed in dental institutions connected with medical schools and universities where the atmosphere is conducive to research. We need to know more concerning dental disease confined to the oral cavity, of teeth harboring primary causative agents for disease in other parts of the body, and of disease in the mouth as a manifestation of systemic disorder. Research on these problems should be carried on by investigative groups who are also associated with the teaching and practice functions of scientific educational institutions.

## The Always Tired Patient

Impressed with the sound sense of Dr. Alvarez' writings, we are pleased to present to our readers a paper giving his recent thought on the above subject. In the thinking of this wise doctor the important thing, from the diagnostic point of view, is to consider the patient as a whole being and to avoid the fallacy of thinking of him as a habitation for disease. The tired, as well as the poor, we have with us always. Dr. Alvarez also emphasizes the value of an understanding heart as a potent therapeutic weapon.

## The Teaching Hospital

Dr. Alan Gregg, commenting lately on the demands for further training by returned medical officers, said: "Though there are many civilian hospitals having no interns or residents, the great majority of hospitals provide internships, and often residencies as well, but without adequate supervision or guidance. No returning doctor wants the kind of internship that teaches him nothing but what he already knows—that he has lost his full competence in civilian life as a sacrifice to military need. Perhaps it is just as well to note that in justice to its patients no hospital can afford to ignore the need of returning doctors for teaching."

Dr. Gregg goes further in his observation and says: "An unexpected result of the war may be this: that the needs of our returning doctors for further education will startle the American people into realizing that the best care is likely to be in the hospital that gives close attention to teaching, and that in self protection we must help to provide for doctors the opportunity to learn as well as to practice medicine."

## Historical Trends In Cancer

Under this title Eleanor J. Macdonald gives in summary an excellent presentation of the historical background of the trends of theory, pathology, surgery, radiology and control measures as applied to cancer. This paper which has been recently reprinted and distributed by the State Department of Health is a timely contribution to an important aspect of the problem of cancer. Physicians who are called upon to discuss the broader views of the situation will do well to familiarize themselves with Miss Macdonald's paper. As Connecticut physicians we are pleased to note under Trend in Surgery the inclusion of the name of Dr. George McClelland, one of America's distinguished surgeons, founder of the Jefferson Medical College and a pioneer in the surgical treatment of cancer. Dr. McClelland had deep roots in our State for he was born in Woodstock in 1796, attended Woodstock Academy,

graduated from Yale College in 1816 and studied for a time with Dr. Thomas Hubbard of Pomfret. He subsequently received his M.D. from the university of Pennsylvania and was Professor of Surgery at Jefferson from 1826 to 1838. Miss Macdonald is statistician, Division of Cancer Research, Connecticut State Department of Health.

## Applications For Extra Food Rations

In an editorial entitled "Mightier Than The Sword," The *New England Journal of Medicine* in a recent issue calls attention to the practice indulged in by many physicians of signing applications for extra food rations for patients, on the supposition that these applications would be turned down by the Medical Advisory Committee. There is hardly any one more contemptible in these days of rationing than the indiviual who lacks the will power to say "No" to requests he knows better than any other are unnecessary and actuated by selfish motives. Placed in a position of responsibility as the physician finds himself, he will, because of the weaknesses of human nature, be subjected to pressure from those who seek to capitalize on his prestige and influence in their effort to secure more of the world's goods than rightfully belong to them. Because the physician is, as our neighboring editor has said, a particularly esteemed public servant, "the public and the nation have a right to expect that he guarantees the honesty of any document to which he affixes his name."

The public is repeatedly guilty of a lack of realism during these years of suffering and want in Europe and Asia. It will not aid the war effort nor develop the character of the individual to indulge in the practice of signing unnecessary ration applications, leaving the onus of rejection to a few more public spirited fellow practitioners.

## No Annual Meeting

The Annual Meeting of The Connecticut State Medical Society will not be held this year. In accordance with the request from the ODT the Council has decided that plans for the meeting be abandoned, but that the meeting of the House of Delegates, probably somewhat curtailed in number, should be held. The feeling has been expressed that, although our convention is devoted entirely to scientific purposes, the reaction of the public is always uncertain and the holding of the meeting might by some be held to be an unpatriotic response to the request of the ODT. The decision of our Council under these circumstances, is therefore, a wise one. The affairs of the Society will not suffer for the single session of the House of Delegates will take care of any business which has to be done. It is hoped that by the time the plans for holding the Clinical Congress are to be considered the restriction may be at least modified and that at a later date we shall be able to look forward with renewed enthusiasm to a fall meeting of the Connecticut State Medical Society.

## Rhode Island Society to Hold Annual Meeting

The Rhode Island Medical Society has announced that permission has been extended to it by the Committee on War Conventions to hold its annual scientific assembly at Providence on May 16-17, 1945. The meeting will be held at the Society's own medical library at 106 Francis Street.

In view of the cancellation of the Connecticut State Medical Society's annual meeting, the Rhode Island Medical Society extends a cordial invitation to Connecticut physicians within reasonable motoring distance of Providence to attend the sessions in the afternoon and evening, May 16, and in the morning and afternoon on May 17. A copy of the complete program will be sent to any Connecticut physician upon request to the Rhode Island Medical Society.

## The Worst Killers

*From The Boston Globe*

America is spending roughly $100,000,000,000 a year for war. This we have to do. Nothing can be done about it. But it is worth noting that all American deaths in the war are only half as many as die every year of heart disease. All the money spent in America on medical research on heart disease comes to less than $100,000 a year.

The four great killers of Americans are heart disease, infectious diseases, cancer and kidney disease. They kill more than 1,000,000 Americans a year. But all the money spent in America to defeat these killers comes to less than $1,500,000 a year.

This is a strange lapse in a very practical nation, that we spare so little to defeat our greatest enemies. The total spent for aid to our medical allies to defend us from premature deaths is pitifully small. Yet America is not unresponsive to appeals to fight disease. The successful crusade against tuberculosis proves that America is right now expressing a great emotional response to one crippling disease, that of

the President. His birthday has become the annual occasion for raising money to fight infantile paralysis. Vast sums are raised. Only a small part of these sums goes to preventive research on infantile paralysis. But even that small part makes a sum five times as great as is spent against heart disease. There are 500 times as many deaths annually from heart disease as from infantile paralysis. The money spent on research for infantile paralysis is $100 for each case of death or serious crippling. For heart disease the amount is 17 cents per death a year.

The diseases of heart, arteries and kidneys together acount for more than 600,000 deaths a year and the number is increasing. Yet in 1940 only $134,000 was spent on the study of all of them together.

Doctors and others have been laying these facts before a Senate subcommittee on wartime health and education. One of the medical witnesses testifies: "There is unanimous agreement that the present sources of support of peacetime medical research are woefully inadequate. In 1940 the foundations gave $4,700,000 for research on medical problems. Estimates of future needs range from $10,000,000 to $50,000,000, If $10,000,000 were available for medical research in 1945 and if this amount were increased progressively until $50,000,000 is available in 1953, I believe this could be spent profitably for important research on urgent medical problems."

Any new source of support, it was urged, should be distributed "according to the importance of the medical problems." Besides the chief killers, cited above, the chronic diseases which take their toll before death by incapacitating the victims—arthritis and rheumatism for example—are reported in urgent need of investigation. Likewise those ailments of ageing, both physical and mental, which cut down the capacities of living.

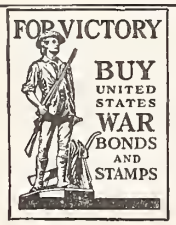
The Council of Medical Service of the American Medical Association proposes establishment of a Federal Authority for Medical Research and Education. It would have it study the needs, recommend public health policy, and allocate funds for medical research in proportion to the seriousness of the disease. They would count a 10-year disability as the equivalent of a death in rating the menace of a disease. They propose that the Authority make initial annual disbursements for medical research of $25,000,000 a year and for medical education of another $50,000,000. It is well known that medical education is the most expensive and the most difficult to maintain adequately by private support. Dr Walter B. Cannon urged that it is useless to assign money for research if the scientific staffs to solve the problems have not been trained. Their training for the task is necessary to the solution.

This is a national problem which the doctors properly bring to national attention. All of us are in favor of long life and health. This is a war in which we shall not have victory until we first train and equip the fighters. They are on our side, and going our way. We are all interventionists in this war. We better give them what it takes to carry the fight against the worst enemies we have.

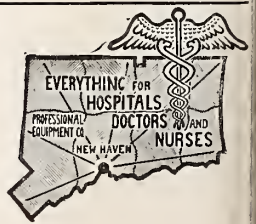
Uncle Dudley

## Diet and Poliomyelitis

Experiments of feeding mice on low and high thiamin diets and subsequently inoculating them with poliomyelitis virus as reported in *Nutrition Reviews* have shown little difference in mortality but a marked difference in the incidence of paralysis. Of the mice given a low thiamin diet, only 9 per cent showed a paralysis by the twenty-first day against 75 per cent of those fed a high thiamin diet. Other experiments suggested that restriction of food was associated with an increase in the resistance of the animals to the virus. Restriction of food was found to be associated with delay in the action of the virus even though the amount of thiamin given was greater than that given a group of mice whose diets were not restricted. Thiamin lack, on the other hand, appeared actually to prevent paralysis in many cases. Restriction of food in some manner seems to interfere with the spread of a virus.




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(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## WHERE CONNECTICUT STUDIES MEDICINE

The number and distribution of Connecticut students in attendance at medical schools has been investigated in preparation for the admission to the State Society of student members. The information which has been obtained is of general interest and pertinence because it may be related, within limits, to the potential supply of physicians in Connecticut in the postwar period.

There are 292 students enrolled at the twenty-seven medical schools from which replies have been received to date. Since the small number of institutions not included in this group are those which may be assumed to have less than five residents of this state in attendance, this figure may be regarded as a fair approximation to the actual total. In view of the drain upon medical and other professional schools effected by modifications in the Selective Service Act, the present enrollment is surprisingly high and does not radically differ from the prewar average of about 320.

| | |
|---|---|
| Yale University School of Medicine | 56 |
| Long Island College of Medicine | 24 |
| Tufts College Medical School | 20 |
| Columbia University College of Physicians and Surgeons | 18 |
| New York Medical College | 18 |
| University of Vermont College of Medicine | 18 |
| Boston University School of Medicine | 17 |
| Harvard Medical School | 17 |
| Total | 188 |

There are 75 Connecticut students studying medicine at the eight schools next listed:

| | |
|---|---|
| Cornell University Medical College | 15 |
| Georgetown University School of Medicine | 15 |
| efferson Medical College | 13 |
| Hahnemann Medical College | 11 |
| University of Pennsylvania School of Medicine | 6 |
| Albany Medical College | 5 |
| George Washington University School of Medicine | 5 |
| ohns Hopkins University School of Medicine | 5 |
| Total | 75 |

Yale University School of Medicine, as would be expected, has the largest enrollment of Connecticut students. In examining the order in which other medical schools follow, however, it is seen that the sequence is materially changed as compared with similar tables for the years before 1942. Assignment of college students to professional schools under the specialized training programs of the Army and Navy is probably the factor of importance in bringing about this altered picture. The assumption that there has been a significant shift in the selection of schools by students is not warranted by the data which are available. Eight medical schools reported an enrollment of more than fifteen residents of Connecticut and the combined enrollment of these schools represents 64 per cent of the total.

The remaining 29 medical students from this state attend eleven schools. These schools are Marquette, Temple, Western Reserve, University of Maryland, University of Michigan, Syracuse University, Women's Medical College, University of Chicago, Washington University, College of Medical Evangelists and Dartmouth.

### March Council Meeting

The regular monthly meeting of the Council was held at the Society's office on Friday, March 2, 1945. There were present: James R. Miller, H. Gildersleeve Jarvis, Joseph H. Howard, Samuel F. Mullins, Arthur B. Landry, Floyd A. Weed, Charles Russman, George H. Gildersleeve, Thomas P. Murdock, Stanley B. Weld and Creighton Barker. Absent: Hugh B. Campbell, Charles T. LaMoure and Robert C. Paine.

### Nominations

Nominations of officers and committees for the year 1945-1946 were considered and are now about

complete for presentation to the House of Delegates meeting on May 23.

## Expenses of the Building Fund Program To Be Borne by the Society

It was voted that the printing, postage and other expenses incidental to the Building Fund program should be paid from the general funds of the Society so that all contributions to the Building Fund will be devoted to that purpose and no deductions will be made for the expenses of the program.

## Second National Bank to Act as Treasurer's Agent

The Council voted to adopt the recommendation made by the special committee appointed to study the administration and control of the Society's funds, Dr. Miller, Dr. Jarvis, Dr. Landry and Dr. Campbell, that the Second National Bank of New Haven be appointed Agent for the Treasurer of the Society. All funds of the Society will be in the custody of the Bank and it will serve as the Treasurer's Agent in making authorized expenditures.

## Student Memberships

Applications for student membership from Connecticut residents who are undergraduates in American medical schools are being received in large numbers. The response received to this new project of the Society is enthusiastic and many comments have been received from student applicants expressing their interest in becoming student members of the Society as a means of developing knowledge of medical affairs in Connecticut.

## Committee On Industrial Health

The Committee on Industrial Health held its monthly meeting in New Haven on Wednesday, March 28.

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## Professor Winslow Retires

Professor Charles-Edward Amory Winslow, chairman of the department of public health at Yale University and for thirty years Anna M. R. Lauder professor of public health, will retire at the end of the current academic year, as announced by President Seymour. He will be succeeded by Colonel Ira V. Hiscock, professor of public health on leave of absence and now serving as chief of the public health section of the Civil Affairs Division of the War Department.

Internationally known for his work in public health and the author of several standard books on the subject, Professor Winslow was trained at the Massachusetts Institute of Technology and taught there for twelve years. He later received the degree of Doctor of Public Health from New York University. Professor Winslow also was a member of the faculties of the College of the City of New York, Columbia University and the University of Chicago. While in New York he served as chairman of the New York State Commission on Ventilation, and since coming to New Haven he has been director of The John B. Pierce Laboratory of Hygiene, which has made fundamental contributions to the physiology of air conditioning and is devoting its resources during the war to studies on the protection of army personnel against extreme heat and cold.

In 1940 Professor Winslow was the recipient of the New Haven Labor Award for his public service to New Haven. He has been chairman of the New Haven Housing Authority since its inception and is now serving as president of the American Society of Heating and Ventilating Engineers.

## Dr. Hussey Goes to Detroit

The Board of Education of the City of Detroit has announced the appointment of Dr. Raymond M. Hussey, formerly professor of pathology at the Yale School of Medicine, to the newly established position of Dean of the Wayne University School of Occupational Health. He assumed his duties on February 15 and on February 28 was honored at a dinner given by the Wayne County Medical Society. At that time Dr. Hussey addressed the members on the subject, "The Future Development of Industrial Health Education in the United States." Dr. Hussey was a member of the faculty at the Yale School of Medicine from 1924 to 1935 and subsequently practiced internal medicine in Baltimore. In 1943 he entered the Medical Corps as a Lieutenant Colonel and was made Commanding Officer and Director of the Army Industrial Hygiene Laboratory at Baltimore. He was recently released from active military service to fill his present position.

## Dr. Osborn Receives Honorary Degree



The many friends of Dr. Stanley H. Osborn will join in congratulating him on his receiving the honorary degree of Doctor of Public Health on February 22, 1945 at Hartford from Trinity College. In presenting Dr. Osborn for this high honor, the presenter made the following statement:

"Trinity honors this fellow Aesculapian of our own Dr. Swan because he has made our State outstanding in the field of public health service. This alumnus of Tufts College has many talents, and many are the steps by which he has attained his high position in his profession. If I were to mention in detail his achievements in public health, you would be amazed at the record of his industry and powers of mind. He conducts his public office with a progressive mind open to new methods. An honest man, he attains his high ends without sacrificing merit to politics, or principle to expediency. For this reason his prestige is high here as elsewhere.

"Past achievements join with present deeds and future hopes to make us mindful of his merit. In the first World War he went on an errand of mercy to the typhus strickent Serbians and Montenegrins, for which humane service he was decorated with the Order of St. Sava. Then, as a lieutenant in the Medical Corps, he devoted his healing skill to the wounded of our country and of Britain. Such a life of service is worthy of citation. I therefore present to you a distinguished epidemiologist, public administrator, lecturer at the Yale Medical School, and—as our own Professor Bissonnette can vouch—a good substitute at a dinner engagement,

STANLEY HART OSBORN,

who deserves to be enrolled as one of Trinity's own, *honoris causa*."

## Colonel Ralph M. Tovell and Captain Max L. Berlowe Awarded Bronze Star Medal

Word has been received of the award of the Bronze Star Medal to Colonel Ralph M. Tovell, MC—AUS, Hartford, senior consultant in anesthesia, Office of the Chief Surgeon, European Theater of Operations. The award was made by Major General Paul R. Hawley, chief surgeon, ETO.

Captain Max L. Berlowe, MC—AUS, New Haven, has been awarded the Bronze Star Medal for meritorious service over and above the line of duty. Captain Berlowe is a member of the Evacuation Hospital Unit and has been overseas since December 1943, now in Belgium.

## Major James E. Crane Decorated

Major James E. Crane, of Stamford, Conn., flight surgeon at the Fort Logan Convalescent Hospital who has seen service in nearly every theatre of war, has been awarded the Bronze Star for his work in the field of aviation medicine.

Col. Robert M. Graham, commanding officer of Fort Logan, presented the medal to Major Crane at ceremonies at which 11 other awards were made.

Major Crane was cited for meritorious service in the South Pacific from January 2, 1943, to May 1, 1944. He commanded the first medical air evacuation transport squadron to function in any theatre of war and "with limited personnel and equipment quickly developed a smooth running unit which met every demand incident to the evacuation of casualties by air from the combat area," the citation stated.

"Later, as flight surgeon of the Army Air Corps Rehabilitation Center in New Zealand, his professional skill and wide experience in the field of aviation contributed much to the personal welfare and

fighting spirit of flying personnel suffering from the strain of sustained combat, who passed through the center," the citation concluded.

Major Crane was born in Stamford, Conn., and received his academic and medical education at the University of Vermont, graduating in 1939. He interned at Stamford Hospital and at Memorial Hospital, New York City. Joining the Army in February, 1941, as a medical officer, he served with the 2nd Armored Division at Fort Benning, Ga., and with the 3rd Armored Division at Camp Beauregard, La., and Camp Polk, La.

Transferring to the Army Air Forces in May of that year, he attended the school of aviation medicine at Randolph Field, Texas, and after graduation in September was sent to the Air Surgeon's Office, Washington, D. C. The following month he was sent from that office as a war combat observer in South America and Egypt. He was in Egypt when war was declared. While there he was put on the staff of Lt. Gen. George H. Brett, present commander of the Carribean-Panama theatre.

Major Crane went to India, China, Burma, Singapore, Java, and Australia before he returned to Washington in July, 1942. Shipping overseas again in December with the 13th Air Force, he commanded the first air evacuation squadron to go into combat in any theatre, operating in the South Pacific.

In June, 1943, he was appointed senior flight surgeon in charge of convalescents at the rest area in Auckland, New Zealand. Returning to the United States a year later, he was stationed at St. Petersburg and Miami, Fla., before coming to Fort Logan in August, 1944, where he became connected with the convalescent program.

## Major Robert Walker Awarded Soldier's Medal

A Ninth Air Force Fighter-Bomber Group, Belgium—Major Robert Walker, 35, of West Hartford, Conn., who wears the gold wings of a flight surgeon in this Belgium-based Ninth Air Force P-47 Thunderbolt Group—has been awarded the Soldier's Medal for rescuing an unconscious pilot from a burning plane.

The Ninth Air Force citation states: "A P-47 type aircraft landed carrying white phosphorous incendiary bombs and fragmentation clusters. One of the bombs exploded nosing the plane over and blowing the engine from its mounting.

"Major Walker, ignoring the danger of further bomb explosions, crawled under the raised plane. Working in pools of leaking gasoline and oil, which were constantly in danger of igniting, he assisted in freeing the unconscious pilot and carrying him to safety."

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## What Is True Optimum Nutrition?

From Professor Elvehjem, in *Nutrition Reviews* we learn that we must integrate all nutritional requirements and realize that we are interested in the performance of the entire organism over its entire life span. The speeding up of growth or performance for short periods of time does not necessarily mean improved nutrition. Optimum nutrition will not result from saturation of the body with cheap vitamins at the expense of other nutrients or the flooding of the body with fats and carbohydrates so that the body systems never need to exert themselves to produce the energy required for the body activities.

It is true that we need proteins, minerals, and vitamins to build the intricate machinery of the body but these systems will not be efficient if they are not given some practice under rigorous conditions. A football player is not supplied continuously with footballs to carry over the goal line; there must be interference if the game is to be interesting. So in nutrition after we have the building blocks we must arrange these blocks into an efficient machine capable of withstanding all the adverse conditions of its environment. The most interesting phases of nutrition lie ahead if we are willing to recognize the laws of both chemistry and biology.




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

## Reports on Efforts to Control Tuberculosis

The Connecticut Committee on Contact Infections of the American Academy of Pediatrics is hopeful that all obstetricians and other Connecticut physicians who practice obstetrics, will give favorable consideration to certain recommendations concerned with further efforts to control tuberculosis.

1. Chest x-rays as part of the premarital examinations.

It is believed that it is fundamental in helping to wipe out tuberculosis and in raising the general standards of physical fitness, to have premarital x-ray examinations of both marital partners. This is of importance equal to that of serological tests for syphilis.

While this measure will not become widespread until such time as it is required by State law, it is believed that it is more fundamental than the following recommendation. It is believed that the obstetricians of the State could do much to further this idea among their colleagues and their patients.

II. Chest x-rays of all pregnant women.

It is recommended that every pregnant woman have an x-ray of her chest as early in pregnancy as possible. This would have two objects: that of protecting the mother, and that of protecting the infant.

A. Protection of the mother.

A woman with a secondary tuberculous infection may find pregnancy and child birth a great strain, one which may cause her resistance to break down and thus lead to a progression of her infection. If this hazard is recognized, it may be possible to safeguard her activities and her nutrition and to make plans for lessening the strain of child birth and thus avoid or minimize the chances of breakdown. Also a suspicious x-ray early in pregnancy will enable the physician by periodic rechecks to decide on his course as pregnancy progresses, and thus plan wisely for both mother and baby.

B. Protection of the infant.

No young child should be cared for by an adult with active tuberculosis. If it is known before delivery that the mother has an active lesion, it will be possible to separate the infant from her at birth and reunite them only after the mother has had sufficient treatment to be rendered non infectious. Thus will be avoided most of the tragic deaths of infants from tuberculosis.

The Connecticut Committee on Contact Infections is hopeful that all pediatricians and other physicians of the state who treat children will give favorable consideration to the following recommendation, the purpose of which is to further extend our efforts toward the control of tuberculosis.

It is recommended that a routine tuberculin test be applied on all children who have reached the age of one year, and that the test be repeated yearly on negative reactors until the age of eighteen.

I. Tuberculin postive children.

The child with a positive tuberculin reaction is definitely sensitized to tuberculosis, and subsequent reinfections may result in the development of secondary, adult or reinfection tuberculosis. Periodic yearly chest x-ray examinaitons of positive tuberculin reactors will often bring to light patients with reinfection tuberculosis at an earlier time when the disease is still in an amenable stage, than would be the case if chest x-rays were delayed until the onset of symptoms.

While most positive reactors will never develop clinical or x-ray evidence of active tuberculosis, it is in the group of tuberculin sensitive individuals that we will find our cases of active tuberculosis of tomorrow and the future.

Tuberculin positive children who are x-rayed immediately following such a reaction will seldom reveal evidence of the nascent primary complex and rarely signs of secondary tuberculosis. This is especially true in children below the age of six. Calcified or fibrocalcific residuals of the primary complex are not visualized as frequently as might be expected in positive reactors even in older children, being seldom higher than 25 per cent, and frequently as low as 6 per cent in the grammar school age groups.

The positive reaction then is not an important indicator of active disease but it is a selector of tuberculin sensitive individuals. Moreover, the positive reaction in a young child points out that the child may very likely live in the environment of an open or sputum-positive case of tuberculosis.

II. Adult contacts with tuberculosis positive children.

Positive tuberculin reactions, particularly in infants and young children, indicate that they have been exposed to an open case of tuberculosis. Since a young child is usually segregated to some extent, it is reasonable to suspect that someone in his close environment may have been responsible for his in-

fection and positive reaction.

Chest x-ray examinations of all adults in contact with a tuberculin-positive young child may very often identify unsuspected cases of active secondary tuberculosis. Thus, the tuberculin reaction routinely used can be of great value in extending the concerted plan for tuberculosis control, and it may be of great value in limiting this type of contact infection.

III. Tuberculin tests.

0.1 c.c. of 1:1,000 dilution of old tuberculin intradermally (Mantoux test) is the standard test of choice. Read in 24-48 hours.

A wheal or raised indurated area, 5 mm. or larger, denotes a positive reaction. A persistently negative tuberculin test in a dilution as low as 1:10 is generally considered to mean that the individual is not infected by tubercle bacilli. The test may become negative in the presence of some infections.

The Patch test is the choice of some. P.P.D. is probably most accurate test material, although it is expensive and there seems to be no added advantage to its use in children.

Florence A. Browne, M.D.,
Cole B. Gibson, M.D.,
Joseph I. Linde, M.D.,
State Committee on Contact Infection
American Academy of Pediatrics

## Radiology Under Hospital Service Plans

REPORT OF SPECIAL COMMITTEE OF THE RADIOLOGICAL SECTION OF THE CONNECTICUT STATE MEDICAL SOCIETY

The meeting of the Committee of the Radiological Section of the Connecticut State Medical Society, which was appointed to confer with the Trustees of the Connecticut Hospital Association on the subject of inclusion of radiological service in the contract of the Blue Cross Plan for Hospital Care, was held at the office of the Executive Secretary in New Haven on June 15, 1944.

Five members of the Committee and six members of the Connecticut Hospital Association were present.

It was ascertained immediately at the meeting that each member of the Hospital Association had already signed with the Blue Cross Plan the contract including x-ray services so that no matter what discussion was to take place, the Hospital Association's Committee was already committed to this procedure. However, a free discussion took place and it was agreed that the Radiological Section's secretary would write a letter to each hospital expressing the feelings of the entire Radiological Section regarding the question of inclusion of radiology in the Hospital Plan. It was shown that the clause "unlimited x-ray work" was definitely objected to by each member of the Radiological Committee.

A suggestion was made for an upper limit of fifteen dollars ($15) in the x-ray expense for any one hospital admission, if it were decided by both groups to accept the inclusion of x-rays at all.

Subsequent to the meeting the Radiological Section held a meeting and the letters promised by the special committee have been sent out to all hospital executive boards and a copy of the letter has been sent to the office of the executive secretary of the Connecticut State Medical Society.

Douglas J. Roberts, Chairman

### COLORADO MEDICAL SERVICE COVERS RADIOLOGY

When Colorado Hospital Service sought approval to extend its benefits to include radiology, pathology, and anesthesiology, the medical society proposed a compromise solution, which was recently adopted. These medical services are now furnished Blue Cross subscribers under a supplemental contract issued by Colorado Medical Service, the surgical care plan operated by the Colorado Medical Society. Pointing out that this method works satisfactorily in their plan, Colorado radiologsits have suggested the following clause for inclusion in Blue Cross plans which seek extension of their benefits to cover certain medical services incidental to hospitalization:

"Professional services of doctors of medicine. Hospital care as provided for by this agreement relates to services to a subscriber who requires bed and nursing care as a part of his medical or surgical treatment. Professional medical or surgical services, that is, professional services which legally can be performed only by a licensed doctor of medicine, are not provided by Colorado Hospital Service. Included under this agreement, however, are certain special professional services, such as anesthesia, electrocardiography, pathology and roentgenology, and in case the attending physician of a subscriber, who is at the time a patient in a member hospital, prescribes any of these professional services, such prescribed services, if customarily available at that hospital, will be provided, to the extent stated below,

by Colorado Medical Service, Inc., under a contractual agreement with Colorado Hospital Service for the furnishing of such services to Colorado Hospital Service subscribers:

"a. X-ray examinations to a maximum of $15 for one subscriber for any one admission.

"b. Laboratory examinations recommended by the attending physician in addition to those provided above.

"c. Basal Metabolism tests.

"d. An allowance of not more than $10 per admission toward the cost of anesthesia."

In Iowa and Washington radiology is not included as a part of hospital care, but is covered in the group hospitalization plan. Payments for x-ray services are made by Blue Cross to the person rendering the service. It is reported that the same method has recently been adopted in Florida.

## Change in Districting of Mental Patients

At a meeting of the State Board on Hospital Districts (see Chapter 88, 1939 Supplement to the General Statutes, Sections 572e, 573e, 574e) held March 2, 1945, it was voted to change existing districts by transferring the towns of Middlebury, Naugatuck, and Prospect from The Fairfield State Hospital district to the Connecticut State Hospital district. This change is necessary in order to equalize the admission rates of the three State hospitals for the treatment of mentally ill patients.

Effective immediately, therefore, residents of the above named towns who are in need of State mental hospital care should be referred to the Connecticut State Hospital at Middletown instead of to The Fairfield State Hospital at Newtown as formerly. Residents of the above named towns who are presently under commitment to The Fairfield State Hospital will not be affected by the change in districting.

## Cancer Campaign Plans Announced

By act of Congress the month of April has been designated "Cancer Control Month." During this period a fund of $5,000,000 will be sought in a nationwide drive by the American Cancer Society under the chairmanship of Eric A. Johnston, to build a coordinated program of research, education and service.

The Connecticut Cancer Society, a branch of the American Society, will conduct the campaign in this state. Governor Raymond E. Baldwin, honorary chairman, has announced the appointment of Oliver T. Osborne, Bridgeport, as State Campaign Chairman. Mr. Osborne is president of the Locke Steel Chain Company. Despite the pressure of wartime duties he recently led the successful fund drive for Bridgeport Hospital, of which he is president, and now has agreed to take the active lead in the State cancer appeal.

Morgan B. Brainard, president of the Aetna Life Insurance Company, Hartford, has been named honorary vice-chairman. Mr. Brainard is also a member of the newly formed Executive Council of the American Society.

A dual form of campaign to reach business and industry as well as family givers has been announced by A. Nowell Creadick, M.D., president of the Connecticut Society. The Field Army, under the leadership of Mrs. Douglass O. Burnham, State Chairman, will conduct its annual campaign of education and membership. Mr. Osborn has named Edwin J. MacEwan, executive vice-president of the New Haven Chamber of Commerce, as state vice-chairman to organize business and industry. Chambers of Commerce throughout the State are cooperating in this work.

Dan Finn, publicity director of the New England zone for Warner Bros. Theaters, will serve as State publicity chairman. A widespread program, including press, radio and billboard coverage and movie theater presentations, is planned.

Of the money raised, the first $17,500 will be retained by the Connecticut Society. The rest of the funds will be divided equally, half to go to the national program and half to remain in Connecticut. Contributions for special purposes may be made provided they are approved by both the American and Connecticut Societies.

Funds of the Connecticut Cancer Society will be used to cooperate in the development of a comprehensive program in the State, particularly in these three fields:

1. Extension of the education of the public concerning the facts about cancer.

2. Cooperation with other agencies in the development of means for the detection and care of persons suffering from cancer.

3. Furthering of research and clinical knowledge.

During the campaign it is expected that speakers will be requested for lay groups, and since physicians are best qualified for this purpose, it is hoped that they will give their cooperation in this and other ways to make the drive a success.

# MEDICINE AND THE WAR

## THE NEED FOR RESEARCH IN A NATIONAL DENTAL PROGRAM

BERT G. ANDERSON, D.D.S., *New Haven*

The Author. *Associate Professor of Surgery, Yale University School of Medicine*

BEFORE beginning a discussion of the necessity for research in the dental field, the question might be asked, "How necessary *are* teeth to the welfare of the individual?" They are probably no more essential for the maintenance of life than the eyes, limbs, or other parts of the body. Many individuals, particularly of the white race, suffer early loss of complete natural dentures without apparent disturbance of digestion or nutrition. A larger number of individuals suffer a partial loss of teeth and come under the classification of dental cripples; that is, persons who have lost a sufficient number of teeth to cause inadequate functioning. It is difficult to prove that toothless people cannot be kept physiologically sound. Modern science can prepare diets, nutritionally adequate, that require no chewing. However, no reasonable person would attempt to convince the American people that they are as well off without teeth, and no dentist or physician would advise his patients to bolt solid food or prescribe a liquid diet exclusively. Aside from the masticating function, teeth are important to us for proper speech. They aid in distinct pronunciation and help command respect for words. They lend grace and dignity to our facial expressions. Therefore, one might consider them as important from the psychological and sociological points of view as from the physiological.

A recent publication from the United States Public Health Service shows that only twenty per cent of the dental needs of our nation are being met. In other words, there exists a great dental manpower shortage. Prior to the present war, a statistical study on dental decay in a large group of persons comprising students at the University of Minnesota and of patients at the Dental School Infirmary revealed that teeth, instead of improving under modern dietary and other dental care, were actually becoming worse. These findings, apparently, have received confirmation through reports coming from Induction Centers throughout the country. There is no disagreement concerning the seriousness of this situation, and no important differences of opinion as to what should be done about it. Everyone will agree that further intense investigation of the problem is urgently called for. No one would condone discontinuing prevention and treatment which is being carried on at present with certainly some measure of success.

Dental disease may be divided into three major groups, which, because of their widespread distribution, merit the attention of those who are concerned with public health. They are: (1) disease of the hard structure of the tooth itself, principally dental decay, (2) disease of the tissues around the teeth, chiefly gingivitis, pyorrhea alveolaris, and periapical infection, and (3) deformities of growth and development of the jaws, namely malocclusion, or irregular alignment of the teeth. Adequate treatment for all individuals suffering from these dental diseases is obviously a great need. Treatment to all in such need might be achieved if we start at once on a program of intensive research on all fronts. Only by this means can we hold out promise of a greater measure of dental health for coming generations.

There are many suggested solutions to the general dental problem. At the present time, demonstrations are being set up to show the effect of the addition of fluorine to drinking water. Those who are engaged in this experiment feel that this may be at least a partial answer to the caries problem. The Dental Service in the New York City Department of Health, has demonstrated that a more efficient organization of manpower has been effective in treating the dental problems of New York City school children. With better organization of the manpower at our disposal widely applied through-

*A Statement given before the Senate Subcommittee on Wartime Health and Education, Washington, December 16, 1944*

out the whole country, they believe the problem might be solved. According to one estimate, there is a present need for five or six times the number of dentists now available in this country. Generously discounting such claims, but allowing that each offers at least a partial solution, it would appear that a health program which is a compromise of all, in which is integrated a definite program of investigation, would carry us a long way toward the solution of the problem.

We should have the courage to take the experimental approach toward dental education by encouraging centers for testing proposed progressive education, by taking the same attitude toward the organization of clinics, especially for school children, and by encouraging research in every dental educational institution in the country. This should be particularly developed in dental institutions connected with medical schools and universities, where the atmosphere is conducive to research. In these places there should be investigation into the natural history of the teeth in health and disease. We need to know more concerning dental disease confined to the oral cavity, of teeth harboring primary causative agents for disease in other parts of the body, and of disease in the mouth as a manifestation of systemic disorder. Research on these problems should be carried on by investigative groups who are also associated with the teaching and practice functions of scientific educational institutions. For research gives life to teaching, and teaching gives permanence to knowledge, and practice gives meaning and direction to research and teaching. The program should provide for the training of capable young dentists who show promise of having exceptional abilities and interest in research. They should be given the opportunity to acquire a sound education in the fundamental sciences and some, at least, obtain a general knowledge of medicine as well as a specialized knowledge of dentistry. Dentistry is a branch of the healing art. A knowledge of teeth in their healthy and diseased states is as necessary to the practice of medicine as a knowledge of medicine and surgery is to the intelligent practice of dentistry. It is obvious that all of these ideal qualifications are not easily attained in the *individual;* however, it is not impossible to realize this ideal in a *group.*

Once a person has been selected for this work and, during a probational period has shown evidence of fitness, he should be permitted to work under a degree of contentment and security. He should be considered something like a good investment, with a reasonable amount of risk attached. Too often capable young people, especially in the field of research, who have dedicated their lives to this work and already gained valuable experience in the field, are compelled to make difficult readjustments and begin anew in other lines of work for which they are not particularly well qualified, because no funds are available to provide them with an adequate living.

In a program providing for sound dental research, fuller educational opportunities, and more efficient organization of existing manpower and facilities, there is hope that healthy teeth will be the birthright of every member of coming generations. There is no argument against using the methods of science to solve dental problems and utilizing more intelligence in dental practice. It is difficult to think of a more worthy cause for the expenditure of public funds.

## Research Council Cancels Medical History of the War

According to *The Journal of the American Medical Association* The National Research Council has announced that the comprehensive Medical History of the War, planned under its auspices, cannot now be undertaken. The Office of the Surgeon General of the Army published the following statement in *The Bulletin of the U. S. Army Medical Department* for October 1944: "Although the Surgeon General appreciates very much the unselfish interest and efforts of the many patriotic physicians and scientists in the development of the National Research Council program, he has expressed the opinion that it should be radically revised to eliminate all accounts of Medical Department activities in this war, until such experience has been published in the official (War Department) history."

Since it would be impossible at this time to prepare an adequate, well rounded history without access to army material, the council now proposes to limit its medical history to a record of the activities of the Division of Medical Sciences during the war period. Plans for the division's history have been formulated and are being developed by the subcommittee on historical records acting through the division's committee on information.

The various services and agencies which had expected to participate in the history have been

notified of the council's decision, and the majority of them plan to draft their own histories independently.

## Army Raises Ceiling to 60,000

The War Department has announced that the ceiling for the Army Nurse Corps has been raised from 50,000 to 60,000.

Under-Secretary of War Patterson said before the House Military Affairs Committee, "The Army's need is for 60,000 nurses. That figure represents the Surgeon General's estimate. We now have 44,000. That is a shortage of 16,000. In addition to relieving that shortage of 16,000, the Army needs 250 new nurses a month to take care of attrition. Unless that shortage is promptly relieved, the wounded and sick soldiers will not get the care they should get. Unless that deficit is made good, the noble, devoted women now serving as Army nurses—in this country and wherever our soldiers are fighting overseas—will be called on to work beyond the limit of their endurance. They are close to that limit now. I have seen plenty of nurses overseas who have been on continuous duty for 18 hours, attending to the critically wounded that have been brought in."

To help meet this urgent need, Procurement and Assignment Service Committees must continue with the greatest possible speed to review the nursing situation in their communities and classify all nurses as available that are not considered absolutely essential to civilian health, and follow-up on those nurses already in Class I who have not responded.

Reports from the Army are to the effect that assignments to date for the month of February are disappointing.

## Captain Larimore Heads New Health Education Unit

A Health Education Unit has been established under the Preventive Medicine Service, Office of The Surgeon General, which combines the functions of the education branches formerly under the Tropical Disease Control Division, the Sanitation and Hygiene Division and the Venereal Disease Control Division.

The primary purpose will be to continue the health education of troops after they have received their formal training and to this end the new unit will develop educational material on the individual soldier's role in malaria and typhus control, prevention of trench foot and other individual measures that protect the soldier's health. It will make use of many of the educational methods so successfully pioneered by the Venereal Disease Control Division.

Captain Granville W. Larimore, MC, former chief of the Education Branch, Venereal Disease Control Division, has been appointed chief of the Health Education Unit. Assisting him will be Captain Vincent I. Hack, MAC, former chief of the Education Branch, Sanitation and Hygiene Division.

## Private Duty Nursing Limited In California

In response to the request of the California State Committee of the Procurement and Assignment Service for Nurses for assistance in meeting the state's military quota, the Board of Directors of the California State Nurses' Association, January 18, 1945, passed the following resolutions:

That the California State Nurses' Association inform all District Nurses' Associations that from this date on any and all official registries shall be closed to Class I and Class II nurses seeking employment in the field of private duty nursing and;

That the nurses in question shall be informed by said registries that it is expected that the private duty nurse with a Class I classification shall apply for military service and that Class II private duty nurses shall take those essential positions made vacant by the withdrawal of Class I nurses for assignment to the Armed Forces.

## Refresher Courses For Medical Officers Reassigned to Professional Duty

Army medical officers who have been occupied with administrative and other non professional duties and who are to be assigned professional duties will be offered the opportunity to take refresher professional training under a new program just inaugurated by the Army Medical Department.

This training, which will be voluntary, will be open to members of the Medical Corps who because of assignment to command, administrative or semi-professional positions have not engaged in the professional aspects of medical service during the past twelve months or more. Priority will be given those who have served overseas.

Requests for this training will be submitted through channels to The Surgeon General who will make assignments to the general and regional hospitals where the courses will be given. Officers

selected will go on temporary duty for a period of not more than 12 weeks.

## Need Now Is For 16,000 Nurses

The Army needs 16,000 additional nurses immediately in order to care adequately for wounded and sick American soldiers, according to Major General George F. Lull, Deputy Surgeon General.

During the first two weeks of February, 1,450 registered nurses received commissions as officers in the Army Nurse Corps. This is an increase over the 1,050 commissioned in January, but the total number of nurses is still far short of the Army's immediate needs.

With the flood of new patients from overseas, the authorized ceiling for the Corps was recently raised from 50,000 to 60,000. At present it numbers only 44,000 and about 250 nurses a month are separated from the Army for various reasons. About 71 per cent are overseas, some having been in foreign theaters for several years. Incidentally, a more effective rotation plan for these overworked nurses will be possible when the full quota of 60,000 is reached.

## Women Medical Officers

There are currently 74 women medical officers serving in the Army, according to the Office of The Surgeon General. Of this number four are majors, 36 are captains and 34 are first lieutenants. They have been certified as internists, neuropsychiatrists, obstetricians, gynecologists, pathologists, radiologists and anesthetists, and the Army has given them assignments in line with their specialties at general, regional and station hospitals as well as at the two WAC training centers. Seventeen of these women medical officers are now serving overseas.

## Closer Association Urged With Veterans' Facilities

The Veterans' Administration is writing to all nurses whose names appear on Procurement and Assignment rosters in an effort to interest them in serving in the Veterans' Facilities. Veterans hospitals are short, at the present time, about 900 nurses absolutely essential to present operations and the need is mounting daily as more and more servicemen and servicewomen are discharged by the Armed Forces. The situation will become even more acute as the new Facilities are completed. Present estimates are that a minimum of 1,000 additional nurses will be needed by June 30, 1945.

## SGO Officers at Senate Hearing

Brigadier General James S. Simmons, USA, Chief of the Preventive Medicine Service, Office of The Surgeon General, and Brigadier General Stanhope Bayne-Jones, deputy chief, were invited by Senator Pepper to testify at the recent hearing held by the subcommittee on wartime health and education of the Senate Committee on Education and Labor. They told the subcommittee about the Army's past and present medical research, testified to the need for civilian medical research and expressed the interest of the Surgeon General's Office in the continuation of an extensive program of military and civilian medical research.

## Disabled Soldiers Relearn Driving

Disabled soldiers at Army amputation centers are learning to drive again under the tutelage of Army reconditioning instructors who have been specially trained for this purpose by the American Automobile Association. Dual control cars are used during part of the training period but the disabled soldiers, once they have learned how to compensate for their physical handicap, are taught to operate ordinary automobiles without any special "gadgets." The instructors prove it can be done. Most of them are themselves "disabled" soldiers!

## American Red Cross To Concentrate Efforts On Class I Nurses

The American Red Cross has instructed Local Recruitment Committees to "concentrate recruitment efforts on nurses classified as available for military service by the Procurement and Assignment Service, senior students and recent graduates but accept applications from other eligible nurses who apply."

## Army Medical Officers Rescued On Luzon

Twenty-one officers of the Army Medical Department, including 13 doctors, 3 medical administrative officers, 4 dentists and a veterinary officer were named in the first list of prisoners freed from Camp Cabanatuan on Luzon, according to the Office of The Surgeon General. The list of those freed from Santo Tomas University, Manilla, included 66 nurses, a physical therapist and a hospital dietitian.

## Army Preventive Medicine Officers Meet

Brigadier General S. Bayne-Jones, USA, deputy chief, Preventive Medicine Service, Office of The Surgeon-General, opened the first session of a conference of Army preventive medicine officers recently held in Baltimore with a summary of the preventive medicine program of the Army.

### ARMY'S PLASTIC EYE

A new plastic eye is being made by the Army which is lighter and more durable than glass and can be tinted to duplicate the appearance of the natural eye and fitted to provide as much motility as possible, thereby avoiding the appearance of staring.

First step in making the eye is to paint the "iris"—a thin celluloid disc, only one-ten-thousandths of an inch thick. The "iris" is then embedded in a tiny plastic lens of acralain—a plastic that has been used in dentistry for the last ten years.

The impression of the patient's eye socket is made with a new type compound, an alignate plastic, that is chemosetting. This, mixed with water to make a paste, is injected with a syringe under the eye lid at body temperature without causing pain or discomfort. It sets to a rubberlike consistency in five minutes and is removed painlessly, giving a permanent record of every tissue contour within the socket. A plaster cast is then made from this replica and used to mold a wax model of the eye ball. The iris button is fitted into the wax and the whole unit is then fitted to the patient. The body temperature melts the wax slightly to produce an even better fit.

A second cast is then made from this wax replica, the wax is melted away and the cavity filled with acrylic resin, tinted the shade of the patient's natural eye ball. This is baked for an hour under a half ton of pressure. When it comes from the cast it has on its front surface the tiny disc of the iris. It is then polished and the "veins" are applied—tiny rayon fibres, an innovation by Captain Don Cash of Beaumont General Hospital, El Paso, Texas.

As a final step, the whole eye is dipped in a clear plastic solution which produces a gleaming coating similar to the layer of liquid covering the natural eye.

This plastic eye is so durable it can be dropped on the floor and stepped on without injury.

Credit for developing the eye goes to three dental officers: Captain Stanley F. Erpf, Major Milton S. Wirtz and Major Victor H. Dietz who were working independently before they were brought together at Valley Forge General Hospital to found the artificial eye laboratory. Technicians are now being trained within 30 days to make these eyes.

### NEW HOSPITAL CAR

On November 13, the first of a new type hospital car for use in the United States was opened for inspection in Washington, D. C.

These new unit-type cars are not converted pullmans, but are designed and built as hospital cars. They are ten feet longer, are air-conditioned, accommodate 38 patients and attendant personnel. Each includes two rows of triple-tiered beds, two compartments with three beds each, a stainless steel kitchen equipped with refrigeration, ice cream cabinet and coal range; a receiving room with four foot side doors for loading and unloading litter patients; two roomettes, each with toilet and shower, for the medical staff or seriously ill patients; and a baggage compartment. The car also carries a modern pharmacy unit and sterilizing equipment and in case of emergency either the receiving room or one of the roomettes can be converted quickly into an operating room.

The Glennon type, steel frame beds are adjustable and unoccupied center bunks can be dropped to provide seating accommodations for ambulatory patients.

Six more of these cars were put in operation in November, 18 in December and 75 during January, February and March of this year—bringing the total to 100, in addition to the 120 converted hospital cars now in use.

### RECORD FOOD INSPECTION PROTECTS ARMY'S HEALTH

The Veterinary Service is concerned not only with the health of animals of the Army, but also protects the health of Army personnel through the inspection of meats, meat-food and dairy products which constitute about 38 per cent of the soldier's ration.

According to Colonel H. K. Moore, VC, Chief of the Meat and Dairy Hygiene Branch, the Veterinary Corps is inspecting over 700 million pounds of foods animal origin per month. The scope of this work may be judged from the fact that the armed forces require each day about 19,000 cattle, 27,000 hogs, 600 calves and 5,000 sheep and lambs—all of which must be inspected to insure that it is fit for food and that it complies with army specifications as to weight, class and grade, method of processing and packaging.

Because food of animal origin more than any other food is dangerous to the soldier's health when contaminated or spoiled, the Army maintains the strictest possible supervision over these products from the time of purchase until the food is served. As a result, says Colonel Moore, no serious widespread outbreaks of disease traceable to the issue of unwholesome meat, meat-food or diary products have occurred among our troops.

### ARMY MEDICAL RESEARCH BOARD

A Medical Research Board has been set up in the Office of The Surgeon General to coordinate all Medical Department research with other staff agencies and components of the Army as well as with agencies outside the Army.

Major General George F. Lull, USA, Deputy Surgeon General, is President, Colonel Thomas B. Turner, MC, Assistant Director, Preventive Medicine Service, is special Assistant to the President and Lieutenant Colonel Leon H. Warren, MC, Chief, Research Coördination Branch, Technical Division, Operations Service, is recorder.

The Executive Committee for the Board includes Brigadier General James S. Simmons, USA, Chief Preventive Medicine Service, Brigadier General Stanhope Bayne-Jones, USA, Deputy Chief, Preventive Medicine Service, Brigadier

General James A. Kelser, USA, Director, Veterinary Division, Brigadier General Rex McKinley McDowell, USA, Deputy Director, Dental Division, Colonel Howard F. Currie, MC, Executive Officer, Supply Service,. Lieutenant Colonel Roy H. Turner, MC, Chief, Communicable Disease Treatment Branch, Medical Division, Lieutenant Colonel John B. Klopp, MC, Director, Technical Division, Operations Service, and Lieutenant Colonel Michael E. DeBakey, MC, Chief, General Surgery Branch, Surgical Division.

## ARMY MICROFILMS MEDICAL JOURNALS

The microfilming service of the Army Medical Library is keeping Army medical officers at remote installations in every theater of operation abreast of the latest published techniques and discoveries.

Starting with 12 medical journals in January, 1943, the list of periodicals microfilmed has grown to 44, covering the whole field of medicines. These are filmed immediately upon publication. Sent by airmail, military intelligence or diplomatic pouch, the rolls of film are in the hands of Medical Department personnel all over the world within 15 days.

In addition to the medical journals, unpublished manuscripts describing even more recent developments are also microfilmed, and upon request sent to our military medical personnel.

The microfilm process saves approximately 95 per cent of shipping space. One 100 foot roll, for example, holds about 1,300 pages or from 12 to 14 journals. Whereas one roll of microfilm weighs about six ounces, the same amount of printed material would represent six pounds.

## ARMY TRAINING RECONDITIONING INSTRUCTORS

The Army now has 680 officers and 1,486 enlisted men who are graduates of training courses in physical and educational reconditioning. More are constantly being trained—not only to take care of the increasing number of convalescents in Army hospitals, but to replace those instructors called to general duty.

Because able-bodied instructors in educational reconditioning are subject to reassignment at any time, every effort is being made to fill these posts from the Army roles of physically disabled. According to the Office of The Surgeon General, these handicapped instructors—many of whom have suffered amputations—are particularly inspiring to the convalescent soldiers they instruct.

## VENEREAL DISEASE PROBLEMS

The Army venereal disease rate for the Continental U. S. rose from 26.3 per 1,000 men in 1943 to 40 per 1,000 in 1944. This increase was due to gonorrhea and must reflect, at least partially, an increase in the incidence of civilian gonorrhea. The syphilis rate declined 20 per cent last year.

The intensity of our venereal disease control program at home has been lowered in part by the overseas assignment of most of the Army's trained venereal disease control officers who were initially stationed here. On the bright side of the picture, the trend of venereal disease rates in most theatres of operations is downward and the combined overseas rate for all American soldiers is now lower than for those stationed in the United States.

## SPORT FILMS IN ARMY HOSPITALS

Sick and wounded soldiers will be able to "attend" big league baseball games, championship prize fights and basketball games played by the Big Ten—while they are being brought home on hospital ships or are patients in an Army hospital. The Office of The Surgeon General has announced that movies of major events in the world of sports are being made an integral part of the Army's reconditioning program. Through the cooperation of the Information and Educational Division, Headquarters Army Service Forces, these sport films are now being distributed to Army hospital and hospital ship film libraries.

## SURGERY OF THE HAND

Dr. Sterling Bunnell of San Franscisco, noted as an authority on surgery of the hand, has been appointed Surgical Consultant to the Secretary of War. He reported to Washington on November 30, and his first tour included Cushing General Hospital, Framingham, Mass., England General Hosiptal, Atlantic City, N. J., Valley Forge General Hospital, Phoenixville, Penn., Newton D. Baker General Hospital, Martinsburg, W. Va., and Wakeman General Hospital, Camp Atterbury, Ind. Surgeons from each general and regional hospital attended Dr. Bunnell's clinics. He will visit the other Service Commands later. Dr. Bunnell's recent book "Surgery of the Hand" is a standard item in the Medical Supply Catalogue.

## WHOLE BLOOD SHIPMENTS START IN PACIFIC

Whole blood shipments to the Pacific battlefront started on November 16. The blood is collected in San Francisco, Oakland and Los Angeles by the Red Cross, typed by Army and Navy laboratories, and flown by Navy plane across the Pacific for joint use by the armed forces.

Although West Coast shipments of ice packed whole blood started on a small scale, over 200 pints a day are now being called for to make the 3 day Pacific flight. Meanwhile, daily flights of whole blood donated in New York, Boston and Washington, cross the Atlantic within 24 hours for use in the European theatre of operations.

## RISK OF INFANTILE PARALYSIS NO GREATER IN ARMY THAN CIVILIAN LIFE

Despite the huge concentration of men brought together from all parts of the country in Army posts and the combat conditions under which great numbers are living, there is apparently no more danger in the Army from infantile paralysis than there is in civilian life.

The Office of The Surgeon General reports that the number of cases was 3.4 per 100,000 troops in this country in 1943 and 4.0 in 1944. The case fatality rate was 12.1 per cent in 1943. This is similar to the civilian rate for similar ages, and there is a further similarity in the time of year the cases occurred and their geographical location.

There has not been an epidemic of infantile paralysis at any Army post during this war.

## POST WAR ADVANTAGES FOR ARMY NURSES

In connection with the present drive for Army Nurses, attention is drawn to the great post war advantages being gained by Army nurses—priceless experience that will put them in the foremost ranks of their profession after the war.

In the words of Major General Norman T. Kirk, The Surgeon General, "The Army Nurse is living five years ahead of the nursing profession. She is handling new drugs, applying new treatments and working with the surgeons who are making history in medical circles during this war. She is gaining experience years ahead of her civilian opportunities." The urgent need for nurses continues to be critical. The Army Nurse Corps appeals to all qualified nurses to join NOW.

## MATCH BOOKS CARRY HEALTH MESSAGES TO TROOPS

Match book covers are being used by the newly formed Health Education Unit, Preventive Medicine Service, Office of The Surgeon General as one means of instructing our soldiers about louse powder, water purification, and the prevention of trench foot and dysentery.

## FOR DETECTING CONTAMINATION BY CHEMICAL WARFARE AGENTS

American troops are protected against the use of contaminated water and food in the event of exposure to chemical warfare agents. Two kits for this purpose have been standardize by the Medical Department: the Kit, Water Testing, Screening; and the Kit, Food Testing, Screening. The latter, which was just standardized last month, can be used to detect chemical warfare agents on both food and food packaging.

## FAMILIES TO RECEIVE REPORTS FROM OVERSEAS HOSPITALS

Under a new plan adopted by the War Department, the family of a wounded or seriously ill soldier is to be kept informed of his condition by the overseas hospital. The first letter dispatched to the family will contain a brief nontechnical description of the soldier's wounds or the nature of his illness. A post card on the solider's condition will then be mailed his family every fifteen days. In return the family is urged to send the overseas patient a "message of cheer" at least once a month.

## IMPROVED FOOD PACKAGE FOR INVALID PRISONERS OF WAR

The latest—and third—version of the food package being shipped to invalid American prisoners of war by the American Red Cross is designed not only to build health, but to boost morale. Tempting recipes by Miss Jane Spinella of the Army Medical School give directions for such delicacies as eggnogs, custards, puddings and welsh rarebits and suggest how to vary the dishes through the addition of flavorings. Miss Spinella also advised on the make-up of the package which contains dried milk, dried eggs, edible starch, oat cereal, salt and pepper, chicken or roast beef, tuna fish, cheese, butter spread, biscuits, peach jam, sugar, coffee, chocolate, vanilla tablets, dates, cigarettes and multi-vitamine tablets. 100,000 of these new-type packages are now ready for shipment.

## ARMY INSECT AND RODENT CONTROL COMMITTEE

The development and use of insecticides and repellents in the prevention of insect borne diseases among American troops has been one of the outstanding scientific advances of this war. The development of the remarkable insecticide, DDT, was furthered by the formation last February of The Surgeon General's DDT Committee which acted in a supervisory and coordinating capacity. However, since the Insect Control Committee of the Office of Scientific Research and Development is now coordinating basic research on this subject, The Surgeon General's DDT Committee has been dissolved and superseded by a new committee to make recommendations for the solution of all insect and rodent control problems of the Army.

Major General Norman T. Kirk, The Surgeon General, is chairman of the Committee, known as the "Army Committee for Insect and Rodent Control," and Lieutenant Colonel Arnold L. Ahnfeldt, MC, director of the Sanitation and Hygiene Division, Preventive Medicine Service, Office of The Surgeon General, has been appointed Executive Chairman.

At its first meeting, November 27, the Committee reviewed the research and development in insect and rodent control during the past three years and formed subcommittees on Research and Development; Field Uses; Production, Allocation and Distribution! and Training.

## ARMY RECRUITING STUDENT PHYSICAL THERAPISTS

The Army has issued a call for women to become student Physical Therapists. After serving an apprenticeship in Army hospitals, those who qualify will be commissioned as second lieutenants in the Medical Department.

Applicants must be women under 38 who are college graduates with a major in physical education or biological science. They must meet citizenship and physical requirements, and have no dependent children under 14 years of age.

Women who meet these qualifications may apply to the Civil Service Commission or The Surgeon General, U. S. Army, Washington, D. C., for appointment as a student physical therapy aide with a yearly salary of $1,440. Upon satisfactory completion of six months training in Army general hospitals, students become apprentice physical therapy aides at a yearly salary of $1,620, and serve a six months' apprenticeship with emphasis on the treatment of war injuries. Appointments to this latter position are also available to students who have completed an approved six months' course in physical therapy conducted in civilian institutions.

Those who complete their apprenticeship satisfactorily will be commissioned as second lieutenants with a yearly salary of $1,800, an allowance of $21 monthly for subsistence and an initial clothing allowance. These officers will serve as physical therapists in the Army Medical Department, and will be assigned wherever needed in this country or overseas.

### COLONEL LONG AND COLONEL BARKER HERE FROM OVERSEAS

Colonel Perrin Long, MC, Consultant in Medicine in the Mediterranean Theater of Operations and Colonel Marion Barker, MC, Chief of the Medical Service of the 12th General Hospital in that theater, recently arrived from overseas and are now on temporary duty in the Office of The Surgeon General for the purpose of exchanging information relative to problems in internal medicine. Plans have been made for them to visit representative civilian and Army medical installations here. Colonel Barker is particularly noted for his outstanding work in infectious hepatitis for which he has received the Legion of Merit.

### COLONEL CHURCHILL RETURNS

Colonel Edward D. Churchill, of Boston, Surgical Consultant of the North African Theater of Operations, has returned to this country and is on temporary duty with the Surgical Consultants Division of the Office of The Surgeon General. Shortly after his return he spoke extemporaneously at the Southern Surgical Association meeting in Hot Springs, Virginia.

## Medical Corps Officers Promoted to Brigadier General

The Senate has confirmed the President's nomination for promotion of four Medical Department officers to the rank of brigadier general, they are:

Robert C. McDonald, Surgeon, Fourth Service Command, Atlanta, Ga.

Rex McKinley McDowell, Director, Dental Division, Office of The Surgeon General, Washington, D. C.

William A. Hagin, Surgeon, Sixth Army.

Charles B. Spruit, Surgeon, United Kingdom Base.

## Promotions — Changes of Station

Comdr. Charles Y. Bidgood, USNR, Hartford, after eighteen months in the South Pacific has been assigned to the U. S. Naval Hospital, Newport, Rhode Island.

Lieut. Comdr. Andrew Taylor, USNR, Hartford, recently visited his home on leave enroute to his new assignment at the U. S. Naval Hospital, Sampson, New York. Lieut. Comdr. Taylor's recent assignment has been in the South West Pacific.

Lieut. Comdr. Shirley H. Baron, USNR, New London, has been stationed at San Francisco, California, for several months.

D. O'C. Sayers, 1st Lieutenant, AUS, Waterbury, has been promoted to Captain and transferred from Nashville, Tennessee, to Bowman Field, Kentucky.

Joseph F. Sadusk, Jr., Lieutenant Colonel, AUS, New Haven, has been promoted to Colonel and is stationed in Washington, D. C., having returned to this country from overseas duty.

Saul J. Jaiven, 1st Lieutenant, AUS, Stamford, has been promoted to Captain and is stationed overseas.

Howard W. Gourlie, Captain, AUS, Thompsonville, has been promoted to Major, station unchanged.

Lieutenant Commander Mervyn H. Little, USNR, Fairfield, has been transferred from Crane, Indiana, to Quonset Point, Rhode Island.

## War Medicine: Vol. VII, No. 1, January 1945

Apparently this publication has undergone another cut in its number of pages. This issue seems thinner than heretofore and contains very little that could be termed of sparkling interest for the average reader. There is a brief discussion of *Clinical Malaria in Wartime* by Lieut. Col. Francis R. Dieuaide, MC—AUS, in which the treatment of P. vivax and of P. falciparum malaria with quinacrine hydrochloride and quinine are cited and the reasons given for the failure in the former cases. The author is extremely optimistic on the incidence of malaria in this country after the war. From the Montreal Neurological Institute of McGill University are two articles by the same three authors, the first dealing with the effect of morphine sulfate on persons exposed to simulated altitude, the second, with the effect of sulfathiazole on persons under the same conditions. The effect of morphine would seem to vary with the reflex excitability of the individual, whereas sulfathiazole in full therapeutic doses was found to have no deleterious effect on persons at high altitude.

The remainder of the issue comprises a collection of short papers. Dr. Herman E. Hillboe, USPHS, briefly calls attention to the medical aspects of the rehabilitation of tuberculous persons. Lieut. Col. R. E. Tunbridge, Britain's Royal Army Medical Corps, reviews the problem of air blast injuries, citing a few cases. Two Naval physicians present a study of 150 patients with neuroses seen in the South West Pacific area, and suggest the advisability of segregating the milder neuroses from the more serious ones to aid the former to a more rapid recovery. Major A. G. Cohen, MC—AUS, discusses *Relapsing Fever in*

*Panama.* Lieut. Comdr. John B. Dynes, MC—USNR, outlines a rehabilitation program for military hospitals in which the physical and emotional reconditioning are carried along together. The program divides in two directions, depending on whether the casualty is to return to military duty or to civilian life. The neuropsychiatrist is conceded to be the most important cog in this program because of the emotional adjustments necessary on the part of the casualties.

Two War Department Technical Bulletins are included in this issue. TB Med 119 on bacillary dysentery and TB Med 124 on plague. British, Australian, Canadian, Russian and American journals are represented in the Abstracts from Current Literature. There are eight book reviews.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Charles W. Stephenson, Hartford

Army Service Forces, Fourth Service Command
Kennedy General Hospital
28 August 1944

What the heck do you expect by way of interest from one who is not in the army, and confined to the morgue building of an Army hospital? Of course, when you stop to consider the relationship between me and the Army in the last war and in this, there is a bit of humor to be found, in that in the last war, though I *was in* the army I never had a uniform, while in this war, though I am *not* in the army I do have a uniform, regulation Medical Officer's uniform, but without any rank insignia. And I can't wear the uniform when I go down town, else the MP's would pick me up. Now I ask you, what can you expect from a guy like that?

Actually I have the EEG lab going full tilt, together with the nerve testing. Since this hospital is undergoing an alteration in its set-up, a transformation from a General Hospital to a Surgical Hospital, with 500 neuro-surgical beds, and with also a large NP section, the laboratory is also to undergo transformation. We expect in the course of the next couple of months to a good deal more than double the capacity of the lab, with three Galvanic-Faradic machines going full time, and with two EEG machines also turning out miles of brain waves. When that matures I will have to put in a lot less time actually running cases, but for the selected ones, and become a more or less mechanical interpreter and dictator (oral, to a stenographer; not political) and will be hard put to it to keep up with the volume of work.

It is really quite amusing to be in the bizarre position that I find myself in. Though I am a member of the Officers' Club, and attend all "mandatory" Duty Officer meetings, still I have no access to the Commissary, cannot purchase from the QM for myself, and can't even attend the Post Theater. On the average most of the enlisted personnel salute me, just to play safe, and I have managed by this time to return their salutes without grinning. And about every other day somebody stops me with apologies to ask "Excuse me, sir (note the 'sir') but could I ask you a question?" To which I automatically reply "Yes, I know. You want to know what I am." So far I have batted 1.000 on that.

Visiting potentates all are brought into the EEG lab as one of the "show" parts of the hospital, and that at times leads to further amusing situations. One such visit resulted in what I think is the Army's record for promotion. Gen. Reynolds, our CO, introduced me to a visitor as "Doctor, Lt., Capt., Maj., General Stephenson." From civilian through the ranks to General in one breath. That's me, all but the insignia.

So far I have made no startling new discoveries in EEG or in nerve testing, though I have a couple of ideas I want to try out. If they come to anything, I'll give the Connecticut State Medical Journal a shot. About the time that occurs, it will be an honor to have a rejection slip from that Journal.

As for life in the "Sunny South" you can pass the word to John Leonard that I just don't agree with him. Of course I hardly know what Memphis is like, for life consists of 8:30 to 5:00 at the hospital, and during the summer, thereafter sipping anything cold while wearing only shorts until time to go to bed. (And you can tell Hep that despite that bedtime regime I sleep all night without interruption, too.) The country hereabouts is to us very, very flat, and we miss the hills terribly. The highest one I have

seen in seven months was the the banks of the Mississippi as seen from a cruiser on the muddy stream. We will take Lake Champlain, if you please. Or even the Connecticut river.

The people, despite their accent, we have found very pleasant, and we are lucky to have some very nice non medical and non military neighbors. Not that we haven't friends in the other groups too, but it is good to get away from the regimentation at times.

So there's your "case history." You can label it as you wish, NP, GU, or what. Only not OB & Gyn.

I'll be looking forward to the issue of the JOURNAL in which I hope to find many interesting letters from those who have really gotten places. Meantime, my best to the old gang on the third floor of the Prof. Bldg., and all at the hospital.

Chick

2 March 1945

Six more months having gone by, the situation here at Kennedy General Hospital has changed very materially. At the time of my first letter, the rated capacity of Kennedy Hospital was about 3,200 beds. Through a series of summary orders from the S.G.O. this has been stepped up to a rated capacity of 4,387. At the present, this is only 70 per cent filled, with a little over 3,000 patients, but a reserve is being maintained for 1,000 expected neurosurgical patients, all of whom have for the past two weeks been due "within the next few days." In the meantime, the hospital staff has had no parallel growth, with the result that everyone is working overtime.

In my own particular little bailiwick, we have had to double our capacity with a second E.E.G., and are supposed to have ultimately at least five nerve testing machines buzzing full time. This means that we will be expected to report on from 250 to 300 E.E.G.'s per month and from 600 to 800 nerve tests per month. When that gets going in full swing, I fully expect to be snowed under by forms and requisitions in a manner which will make this recent past New England winter look like Florida sunshine and heat.

Despite a third attempt to alter my status with a full fledged commission, I once more have been turned down. A positive diagnosis of TB has been made but the darned bugs are so avirulent that the guinea pig innoculated with a culture of them is progressing nicely toward an arteriosclerotic old age. So far as I know, I am not yet headed for Saranac—in fact, I have greater difficulty to keep from gaining too much weight, despite the constant pressure of keeping up with the case load.

No one from Hartford is around here right now, though, of course, Ed Schlesinger was here a while ago. Hunt Jones is located nearby, being located at Millington in the Navy's big installation which is but 17 miles from Memphis. I have seen him a couple of times, but visiting around just doesn't exist so far as we are concerned. McIntyre, who came here straight from his internship at the Hartford Hospital, dropped in to make himself known and at that time brought me somewhat up to date on odds and ends regarding transitions in my old orbit. When last heard from, he was out in the neighborhood of San Diego.

The battle of Memphis goes on. Two thousand neurosurgical beds are going to be something to keep up with. I hope when it's all over there will be enough of me left to get back to the old stamping ground to say howdy. I trust that I will not have picked up so much accent that I will have difficulty making myself understood.

Chick

## From Captain Aaron Levy, AUS, Winsted

India

November 19, 1944

Your letter has just arrived and I am glad to do as requested. It does not appear likely that it will arrive in time for the purpose, but there will be not much lost as my experiences have not been very exciting.

After a few months in England I was posted to India, arriving in June 1942, and was immediately attached to an armored division, most of the time in a field ambulance which supplied the medical services to a tank brigade, the balance of the time (6 months) as medical officer to one of the tank regiments which composed the brigade. This regiment was finally dissolved and I reverted to the field ambulance.

As a result of certain changes made some time ago, I have been attached to a base hospital for the past 6 weeks, a beneficial change from the point of view of practising medicine, and expect to remain here until the field ambulance actually goes into the field.

You have probably heard from many other services all about the tropical diseases and I won't say

anything about them. I have personally managed to avoid malaria, but fell foul of amebic dysentery and dengue fever. The dysentery was atypical and ran me down quite a little before I realized it was not unsuccessful acclimitization and went into the hospital as a patient.

The brighter aspects of this here army life has been the opportunity to meet and know people of other nationalities, and to travel. Circumstances permitting, leave is allowed once a year, and I have been to Kashimir and Darjeeling. The former place is magnificent and for the first time I was above the snow line—16,000 ft.—although it was mid-summer.

I will be very glad to get home.

Aaron Levy

## From Lieutenant Commander Reinhold F. Hertzberg, USNR, Stamford

10 February 1945

Thank you for your post card asking for verification of my address. I shall be delighted to be kept on the mailing list of the JOURNAL as it is one of my few ties with home. I seldom see anyone from our part of the country and local news is scarce out here, deep in the Pacific.

Reinhold F. Hertzberg

## From Captain L. F. Castaldo, AUS, Bridgeport

10 February 1945

I am sorry to be answering the card you sent me at such a late date, but I assure you this is because the card has just reached me. For the past 2 months the mail situation has been quite bad—and only recently has it been coming through more promptly. However, I wish to inform you that the address you received from Dr. Barker's office is correct, and can be used on your mailing list. I shall appreciate getting any and all issues of the JOURNAL if still available. Since you are probably well acquainted with the Aux. groups, and how the various teams function, I shall omit saying anything about them that is probably just so much repetition. We all look forward to a speedy climax to the war, and a chance to return home to resume our private lives in peace and happiness which are so lacking here. My sincere regards to the society and its members at home and abroad. It will soon be Spring in Connecticut which makes me kind of homesick.

Capt. L. F. Castaldo

## From Lt. Col. Joseph J. Pagliaro, AUS, Shelton

February 28, 1945

I have just received your card of January 21 and hasten to submit a corrected address to your office.

The JOURNALS have been forwarded to me in the past and I can assure you that not only have I enjoyed the articles written in them; but I was also very glad to learn of the whereabouts of many of my friends.

At present as you can see by my address I am Staff Surgeon for the Army Air Force Engineer Command in the Mediterranean Theatre of Operations. Our command is concerned mainly with the construction and maintenace of air fields in this theatre.

It might also be of interest to you to know that Capt. Anthony J. Pepe is surgeon for one of our Aviation Engineer Bn's.

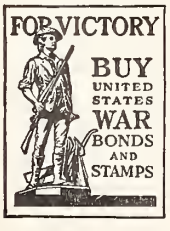
Again, let me thank you very much for sending me the JOURNAL.

Joseph J. Pagliaro

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## Women in the Medical Services

The U. S. Department of Labor, Women's Bureau, has issued two pamphlets on *The Outlook for Women in the Medical Services*, Bulletin 203, Number 1, entitled *Physical Therapists*, and Bulletin 203, Number 2, entitled *Occupational Therapists*. Both are illustrated.




MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
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*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## The Tomassetti Health Insurance Bill

House Bill 601, introduced by Nicholas J. Tomassetti (d), Representative from New Britain, is "An Act Concerning the Establishment and Administration of a System of Health Insurance and Making an Appropriation Therefor." The bill is set forth on twenty-nine typewritten pages and as is usual with health insurance bills, it goes into great detail concerning administration and what might be the political phases of such a law but gives only a slight consideration to standards of quality of medical care that would be provided. The origin of the measure is not known at this time.

The Bill provides for a Commissioner of Health Insurance and a Commission of 15 members to be appointed by the Governor. The Commission will include the State Commissioner of Health Insurance, the State Commissioner of Health, three physicians, one dentist, four representatives of employers, four representatives of organized labor and one representative of hospitals. The Commissioner of Health Insurance shall receive a salary of $10,000 per annum and expenses. Members of the Board will receive $20 per day and traveling expenses when engaged in the work of the Board.

Generally speaking, it will cover all employed persons with provision for voluntary insurance by others. Financing will be through 1 per cent of the payroll to be paid by the employer and matched by a like 1 per cent to be paid by the State. A general computation arrives at a total annual income of 25-26 million dollars, half from the employer's tax and half from the State. This is based on 1944 payroll for employed persons in Connecticut of 1 billion three hundred million. This does not include persons employed by the State or political subdivisions. Where the State will derive its contribution—12-13 million—the Bill does not provide. Except for voluntary participation no payment is to be made by the employee.

The medical services to be furnished would include general care and services of specialists, laboratory services, maternity benefits and nursing outside of a hospital all for periods not to exceed 26 weeks after any disability of sickness or injury. Conditions covered by other state, federal or municipal benefits are not included. Dental service for the "relief of pain" is provided.

The Bill would provide cash benefits, commencing after 7 days, when a loss is sustained due to disability and in amounts provided by the State Unemployment Law.

Administration shall be by the Commissioner of Health Insurance through local offices under a local financing manager and a local medical manager (physician) who shall be full time employees serving on an annual salary basis. Outline of areas served by local offices is not stipulated. In each local area there will be a local council and a local advisory committee. The local council shall supervise, the collection of premiums, the payment of cash and maternity benefits, the furnishing of medical benefits, cooperate with the local public health officers, prepare and publish lists of general, medical and dental practitioners, surgeons and other specialists, pharmacists, hospitals, clinics and laboratories and "to fix the manner and make arrangements for remunerating general medical and dental practitioners, surgeons, medical and other specialists, nurses, groups of such practitioners, pharmacists, hospitals, clinics, laboratories and the other persons and agencies furnishing the medical benefits. Each local council shall be free to adopt such modes or combination of modes as in its opinion seem best, subject, however, to the supervision, direction, control and approval of the Board."

"Any one of the following modes may be adopted for remunerating general medical practitioners. (1) a salary system, (2) a per capita system, (3) a fee system, (4) any combination or modification of above and (5) special arrangement with a group of

practitioners. No mode for remunerating general medical or dental practitioners shall be adopted for any local area without the consent of a majority of the general medical or dental practitioners, respectively, in that locality who have agreed to furnish medical benefits under this act."

Eligibility. Every general medical and dental practitioner, duly licensed to practice in the State (without discrimination against any school or mode of practice which is lawful in the State) shall have the right to be included in the list of physicians furnishing medical benefits.

Referees. Referees in hearings on appeals as provided for and recourse to the Superior Court.

The Appeal Board shall consist of three members, including a representative of organized labor, to be appointed by the Governor. Salary $6,000 per annum per member. This Board shall appoint in the competitive Civil Service regular and medical referees. Medical referees shall be licensed physicians or dentists.

Health Insurance Fund consists of all premiums and money paid in for the purpose of this Act and shall be administered by the Comptroller.

Appropriation. The sum of $100,000, or so much thereof as may be necessary, is appropriated for the purpose of operating until one month after the date on which premiums accrue and become payable.

## NEWS FROM WASHINGTON

### Health Insurance In Washington

The Social Security Board wants broadened unemployment compensation, extended old age pension system, health insurance for everybody and centralized control at Washington. This policy would disappoint all hopes of the development of state systems, would permit Washington to dictate security policies and give the Treasury complete demand over security taxes. The result would be national standards applicable to all states without respect to local conditions or achievements. The cost of this over-all security for everyone has not been officially computed for publication. Unofficially it is believed that the twelve per cent payroll tax in the original Wagner-Murray-Dingell Bill would be required, six per cent from the employer and six per cent from the employee. Cost figures will be taken from official seclusion when hearings begin.

The American Taxpayers Association, commenting on security legislation, says, "The Government contribution lies in advisory and supervisory functions rather than in the establishment of an administrative organization of overwhelming size." Of health insurance the Association says, "The promise for a happier and healthier United States seems to lie with the extended activities of private groups rather than with enormously expanded government service at the cost of our nation's enterprise but can produce, create and achieve only so long as it is free."

The Wagner-Murray-Dingell Bill establishing a federal health insurance system has been reintroduced into this Congress. It was submitted to the last Congress but died without hearings. It is likely it will die again, especially if Congresss is appraised of home opposition. Senator Wagner is reported to have a bill of his own that differs from the bill he introduced last year. Introduction of Senator Wagner's bill may be expected at any time.

The Hill-Burton Bill—S191—authorizing a national survey of hospital facilities and providing for the construction of hospitals, should be watched. The bill also provides for the establishment of health centers. This legislation is sponsored by the American Hospital Association and had been approved in principal by the Board of Trustees of the American Medical Association. Opinion is that this is the first real scientific approach by means of national legislation toward the problem of distribution of medical care, where the need can be shown. Unlike previous federal problems, this bill leaves control in the hands of local communities.

### For the Deferment of Medical and Dental Students

S637, a bill designed to increase the supply of physicians and dentists for the civilian population, especially in rural areas, and for the armed forces, has been introduced in the United States Senate and is now pending before the Committee on Military Affairs.

The President is authorized by this measure (1) to provide for the release from active duty of men who have a record of more than one year of honor-

able service in the armed forces and who have completed a substantial part of medical or premedical education and training, in order to pursue further such education and training; (2) to provide for the Selective Service deferment of men who are enrolled in the national medical and dental education program established by this act.

The national medical and dental education program limits the period of premedical preparation to two years and restricts the number of men who may be enrolled at any one time in premedical or medical courses. The operation of the plan is made contingent upon military operations and the essential needs for physicians of the civilian population and of the armed forces.

This bill was drafted after consultation with the Council on Medical Education and Hospitals of the Association and the Executive Council of the Association of American Medical Colleges. It embodies the broad principles outlined by these two groups so far as the deferment of premedical students is concerned. It would effectuate the recommendation made by the House of Delegates last June, namely, that action be taken by the President or the Congress "to correct the current drastic regulations which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools."

## Prepaid Medical Service — East Versus West

A comparison of two Governors' messages to their Legislatures is worthy of observation.

In California, Governor Warren said: "It is now generally agreed that we cannot bring proper standards of health to the people of every community through voluntary programs.

"We have had enough investigation and enough talk to be ready for action."

Governor McGrath of Rhode Island said: "It is obvious that no plan of universal prepaid hospitalization or health care can be put into effect until we are sure that the services for which prepayment is made can be met by adequate facilities."

Rhode Island was the first and still is the only State that has enacted a Cash Sickness Law. A one per cent contribution by exployees. It is not considered successful at present because the payments exceed the income. This is due to administrative difficulties. Workers whose illness is connected with an occupation may receive aid from both the Workmen's Compensation and the Cash Sickness Fund.

Maternity claims exhaust their credits by taking advantage of a sickness period oftentimes running to five and six months. Governor McGrath in his message to the Legislature has called attention to the need of a review of the financial situation of the Fund and the necessity of certain changes to protect the Plan.

*Eleven states have introduced bills to permit Sickness Compensation and most of them sponsored by labor.*

## Medical Supply Surplus

Congressman Miller, Nebraska, has called attention to the sale of 27,000,000 packages of gauze bandage at Louisville, Kentucky, and 11,700,000 at Pueblo, Colorado, while at the same time, the Surgeon General of the Army is calling for 43,000,000 surgical dressings. Also listed for sale are 121,000 hospital mattresses, plus tens of thousands of items like syringes, needles, drugs, 200,000 tubes of catgut, while factories are working twenty-four hours a day to produce similar items. The Mead Committee has promised to hear Dr. Miller and have promised to investigate what appears will be a source of constant scandal.

## Senator Pepper Speaks

From the *Congressional Record Monday*, February 5. The Pepper Sub-Committee on Education and Health received an appropriation of $15,000. $25,000 was asked for the 79th Session.

Statement by Senator Pepper: "I want the Senate to know that we are not out for Socialized Medicine. We are not out to break down the standards of the profession. We do not have any panacea. We are merely trying what we may properly do to bring a greater degree of health to the nation."

## A. M. A. Council on Medical Service and Public Relations Reports on "Health Needs of Veterans"

"Health Needs of Veterans" is the title of the fourth interim report of the Subcommittee on Wartime Health and Education which was released Febrary 26 by Senator Claude Pepper, Florida, Chairman.

"Every possible step must be taken to make certain

that good medical care is within the reach of every veteran," the report maintains, and although the committee says that "its first consideration is the care of those disabled as a result of military service," its proposals indicate great concern over medical care for all veterans regardless of whehter or not their disabilities are service connected.

TWENTY MILLION VETERANS OF ALL WARS

The committee estimates that between 1,500,000 and 2,500,000 will suffer disabilities due to war.

The committee estimates that in the postwar period, veterans of this and previous wars will number 20,000,000, or one out of every seven of the entire population while veterans with their families will make up one-third to one half of the nation. This is the group which the committee proposes to look after—and as the G. I. Bill of Rights does not assure medical care for all veterans the committee recommends studies, investigation and legislation which would insure medical care for all veterans. The committee points out that the G. I. Bill authorizes appropriations for great expansion of Veterans' Administration facilities and states that "actually more than 93 per cent of the patients admitted in 1942 were treated for ailments not connected with service."

CRITICISM OF VETERANS' ADMINISTRATION

The committee states that criticisms of the quality of medical services given by the Veterans' Administration comes from those who speak authoritatively and proposes to investigate this lack of quality in medical care. This is especially necessary as the Veterans' Administration contemplates a billion dollar development in the next twenty years. But even this expansion cannot afford adequate care and hence the committee recommends care of the veteran locally.

"From the point of view of veterans who will not have sustained service-connected disabilities, the medical care program of the Veterans' Administration will not be adequate because it does not include out-patient care for them," the report continues. "Medical care of the individual should be a continuous process under the same medical supervision. It is desirable that the same physician or group of physicians should be acquainted with the patient in health and illness if the best care is to be given. . . . The problem must be dealt with as part of the larger problem of assuring adequate medical care in every community. . . . *The medical care of veterans not having* service-connected disabilities should be considered mainly the responsibility of the communities where these veterans live. . . . It would be well now for localities to begin now to plan their health programs on this basis."

(This proposal of local care by the committee is reminiscent of the Shoulders' plan which was presented but not followed after World War I.)

The report stresses the problems of mental illness and says that these will include not only those receiving medical discharges from the army, but also those who "will find it difficult to readjust themselves to civilian life." The committee recommends the establishment of 1,300 mental hygiene clinics!

Again despite definite proof to the contrary the committee places the burden of the blame upon the medical profession for the fact that 40 per cent of the men of military age did not meet the Selective Service requirements for general military service. "This was a reflection on the organization of medical care in this country since we know that a considerable proportion of the defects which cut so deeply into our potential fighting man power *could have been prevented or remedied* if good medical care and adquate preventive measures had been available to the whole population," the report declares.

SUMMARY OF RECOMMENDATIONS OF THE COMMITTEE FOLLOWS

"1. Full medical care by the Veterans' Administration should be made the right of every veteran who has sustained a service-connected disability, whatever the origin of the condition for which he needs treatment. Care should include hospitalization and out-patient treatment for all of his ailments.

"2. In order to assure availability of adequate medical care for the great body of veterans—13,000,000, more or less—who will not have service-connected disabilities, measures should be initiated as promptly as feasible to meet the medical needs of the whole population, in accordance with recommendations set forth in the subcommittee's Interim Report No. 3 on the Nation's health.

"3. Expansion of Veterans' Administration hospital facilities should be carried as far as may be required to assure full care of veterans with service-connected disabilities. It would be medically and economically unsound to set up medical facilities for all other veterans separately from the provisions which must be made for the whole population. It is desirable, however, that the Veterans' Adminis-

tration should continue to provide hospitalization, when beds are available, for care of any veteran unable to pay for such service or to obtain it in his own community.

"4. Federal, State, and local governments, and public and voluntary agencies, should cooperate to develop a network of mental hygiene clinics for the maintenance of mental health among veterans and the whole population.

"5. The whole program of educational, employment, and monetary benefits for veterans should be reexamined in the light of accumulated experience in order promptly to bridge gaps and remove inequalities which interfere with the health and welfare of veterans. Among obvious needs are extension of social security credits under the Federal Old Age and Survivors' Insurance Act, dependency allowances for families of the disabled, and inclusion of merchant seamen among those eligible for educational and unemployment benefits.

"6. In order that every possible step may be taken to safeguard the health of disabled veterans, the subcommittee proposes to examine and appraise both the quality of the medical services given in Veterans' Administration facilities and the ability of the Administration to discharge the heavy duties which will be placed upon it. Special attention will be given to neuropsychiatric services. The investigation will be conducted with the help of recognized authorities in various medical specialties, of veterans' organizations, and of professional groups."

## New Bills In Congress

HR1442—by Dr. Miller of Nebraska. A Bill to Amend the Social Security Act so as to Aid the States in Providing Certain Medical, Surgical and Hospital Care. Referred to the Committee on Ways and Means.

*Comment:* Dr. Miller feels that there is too little uniformity with regard to appropriations by States for the medical care of the aged and the amount generally is too small to provide the services in an adequate way. His suggestion is that the States should contract with insurance companies to provide this service and he believes that the small amount that is now expended on each individual would be sufficient to pay the premium on a policy that would give them much better services. He suggests that the insurance scheme could be somewhat similar to that under which our Workmen's Compensation plans are operating.

HR1513—by Mr. Kilday of Texas. A Bill to Provide Dispensary Treatment and Hospitalization in Army and Navy Hospitals for Retired Enlisted Men of the Army, Navy, Marine Corps and Coast Guard. Referred to the Committee on Military Affairs.

*Comment:* Mr. Kilday introduced this bill at the suggestion of many retired service men in his community who would like to use the Army and Navy hospitals in that community where the veterans' facilities are not accessible.

HR1661—by Mrs. Rogers of Massachusetts. A Bill to Authorize the Establishment of A Permanent Veterans' Medical and Hospital Service in the Veterans' Administration, and for other purposes. Referred to the Committee on World War Veterans' Legislation.

*Comment:* Mrs. Rogers carried a bill in the last Congress establishing similar provisions for nurses. This year she has enlarged the bill so as to include other workers. She says she hopes by this bill to help secure adequate personnel . . . doctors, nurses, technicians and others for the veterans' hospitals.

HR1699—by Mr. Short of Missouri. A Bill to Establish an Optometry Corps in the Medical Department of the United States Army. Referred to the Committee on Military Affairs.

*Comment:* This bill was introduced at the request of optometrists and aims to have the optometrists commissioned in the Army.

HR1997—by Mr. Hebert of Louisiana. A Bill to Regulate the Practice of Optometry in the District of Columbia. Referred to the Committee on the District of Columbia.

*Comment:* Mr. Hebert fears that much harm is being done by untrained persons trying to treat the eyes, fit them with glasses. He believes his bill is a needed public protective measure.

HR1998—by Mr. Hoch of Pennsylvania. A Bill to Establish A Chiropody (Podiatry) Corps in the Medical Corps of the United States Army. Referred to the Committee on Military Affairs.

*Comment:* Mr. Hoch introduced this bill by request. He is persuaded that the chiropodists do good work and that the Army should have the benefit of their knowledge. He had a similar bill before the 78th Congress.

HR2020—by Mr. Voorhis of California. A Bill to Amend Title X of the Social Security Act. Referred to the Committee on Ways and Means.

*Comment:* Mr. Voorhis had a similar bill before the 78th Congress. He wishes to provide a uniform national program for the care of the blind.

# STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

## CHANGES IN STATEWIDE REGULATIONS AFFECTING LABORATORIES

STANLEY H. OSBORN, M.D., *Hartford*

THE Public Health Council of the State of Connecticut, at their regular February meeting amended Regulations 39, 40 and 41 of the Sanitary Code which regulate public health laboratory activities.

Regulation 39 relates to examinations by approved laboratories that may be required by health officers when the control or release of a case, contact or carrier of a communicable disease is dependent upon laboratory findings. The regulation has been revised to specify that such specimens must be examined in the Bureau of Laboratories of the State Department of Health or in a laboratory specifically approved for the purpose. When the control or release of a case, contact or carrier of a communicable disease is dependent upon laboratory findings, the health officer is now required, by himself or his agent, to secure and submit release cultures or specimens for examination.

Regulation 40-B, in force since shortly after the Marriage License Law was enacted in 1935, has required that any person in charge of a laboratory which conforms to the requirements and standards required by the State Department of Health for performing a particular test or tests for syphilis may be designated as an approved laboratory. By regulation, a standard laboratory blood test is a serological test for syphilis performed for marriage license law or prenatal law purposes providing it is performed in a manner that meets the approval of the State Department of Health.

The revision of Regulation 40-B continues in force the above requirements but adds requirements for serological tests performed for other purposes. Under the revised regulation it will be necessary for any person performing a serological test for syphilis to have demonstrated to the State Department of Health proficiency in performing the particular test and to hold an unexpired certificate to perform that test. The requirement exempts from these provisions only those serological tests that are performed entirely for instructional, research or experimental purposes and serological tests performed in a laboratory maintained by a physician for use only in his private practice.

The provisions of Regulation 40-B requiring that all persons shall hold certificates for performing serological tests do not go into effect until July 1, 1945. In most of the hospital and privately owned laboratories where tests are done for premarital and prenatal law purposes there are one or more persons who have met these requirements for the test they are now performing although they do not yet have the certificate which will be required. Arrangements have been made for those persons upon application to the Department to receive the necessary certificate before July 1. Any person so qualified should make application for the certificate to be issued. It will be necessary for persons in laboratories other than the above to apply for the required certificate if serological tests will be made after July 1, 1945.

Regulation 41 of the Sanitary Code requires that laboratories must report positive findings. Up until now the regulation has required heads of laboratories to report results of examinations of body fluids, secretions or excretions whenever they have found "evidence indicating the possible existence of a communicable disease." That wording had been considered too inclusive by many health officers and laboratory heads because, for example, it would require reporting any type of pneumococcus or any beta hemolytic streptococcus that might be found in the examination of a throat culture. It has been properly argued that such findings often have no significance indicating the presence of communicable disease. As revised, Regulation 41 requires that any person who makes an examination of any specimen of material derived from the human body—or who is in charge of a laboratory in which such examination has been made—must report any significant microscopical, cultural or immunological evidence or other significant manifestation of the

presence of any one of a list of diseases specified in the regulation. The report is to be made to the local health officer of the town from which the specimen was obtained and must include the name and address of the person or persons from whom the specimen was obtained and the name and address of the physician for whom such examination or test was made. The diseases to which this regulation applies at present are:

Actinomycosis, amebiasis, anthrax, brucellosis, chancroid, cholera, diphtheria, bacillary dysentery, favus, glanders, gonococcal infection, hookworm infestation, leprosy, malaria, meningococcal infection, paratyphoid infection, plague, rabies, rickettsial infections, salmonella infection, syphilis, trichinosis, tuberculosis infection, tularemia, typhoid infection, virus infections, whooping cough.

## Health Transcriptions Available For Broadcasting

The State Department of Health has secured four sets of Health Transcriptions prepared by the Bureau of Public Health Education, American Medical Association.

Transcriptions are offered to local medical societies, free of charge, for use on local radio programs. These have been prepared by radio professionals from authentic medical sources. They should aid the physician who is anxious to have authentic health information given to the public but is too busy, these days, to broadcast this information himself.

A folder giving details and titles of each transcription in the series will be sent on request. These are grouped under four general titles as follows:

1. Before the Doctor Comes (sixteen ten-minute interviews in which the mother asks the doctor what to do about it).

2. Dodging Contagious Diseases (twelve ten-minute interviews with the doctor showing how to avoid or how to deal with contagious disease problems).

3. Live and Like It (twelve fifteen-minute dramatized health broadcasts).

Another group is available, Health Heroes, including twelve quarter hour health stories. These have been prepared to fit any text or teaching plan in schools, Grades IV-VI.

Radio stations are equipped to use transcriptions which require a machine running at 33⅓ revolutions. Victrolas run faster—78 revolutions—so these transcriptions cannot be used on a victrola.

If equipped with the proper machine local health departments may, with the medical society approval, make use of this excellent material for group meetings.

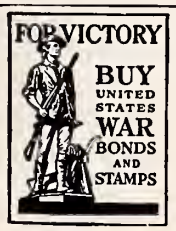
Application for local use of transcriptions may be made direct to State Department of Health, Hartford, Connecticut, or through the State Medical Society, 258 Church Street, New Haven.

## Health Progress in South America

Venezuela's No. 1 public health problem, the parasitic disease called schistosomiasis, is being attacked on a mass scale under a campaign recently launched by the Venezuelan government in cooperation with United States technicians of the Institute of Inter-American Affairs. The schistosomiasis control program is only one phase of the cooperative health work planned for Venezuela under the recently extended agreement whereby Venezuela and the Institute each contributed $500,000 to continue the joint health work.

In support of Brazil's ambitious health and sanitation program, that country's federal and state authorities are currently making a determined effort to secure adequate numbers of all types of public health specialists.

Haiti has succeeded in bringing malaria increasingly under control through an intensified program of cooperation between the Haitian government and the American Sanitary Mission. An anti-yaws program has also been carried out in Haiti where it is estimated that there are more than 500,000 cases of this disease in a population of 3,000,000. From 15,000 to 20,000 treatments are being given weekly in several yaws clinics with an estimated cure of 50,000 cases.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. H. Bertram Lambert, Bridgeport
*Vice President*, Mrs. Creighton Barker, New Haven
*Secretary*, Mrs. Charles W. Goff, West Hartford
*Treasurer*, Mrs. Julian G. Ely, Lyme

### Board of Directors Meet

A meeting of the Board of Directors was held on February 12, at 1:30 P. M. at the office of the State Medical Society in New Haven. It was decided at this meeting, that the Woman's Auxiliary of the State Medical Society shall hold the annual meeting on May 23 at 2:00 P. M. at the New Haven Colony Historical Society, 114 Whitney Avenue, New Haven. There will be a Board of Directors meeting at 11:00 A. M. on the same day, and another Board meeting immediately following the annual meeting.

### Middlesex County Meeting

The organizational meeting of the Middlesex county Woman's Auxiliary took place at the home of Dr. Jessie N. Fisher, Portland, on February 14. Mrs. G. M. Craig, temporary chairman, presided. Twenty-five charter members were present. Members of the nominating committee were: Mrs. Lloyd Miner, Mrs. Edgar Yerbury and Mrs. Philip Schwartz. The following slate of officers was presented and elected: President, Mrs. Walter N. Nelson; President-elect, Mrs. G. M. Craig; Secretary, Mrs. Louis O. LaBella; Treasurer, Mrs. Charles Russman. Dr. Fisher addressed the meeting and outlined the purposes and methods of work of the Auxiliary. A social hour followed the business meeting with Mrs. Alfred Sweet and Mrs. William Joyce presiding at the tea table.

### Hartford County Meeting

The annual meeting of the Woman's Auxiliary of the Hartford County Medical Association will be held on April 3, at the Hartford Club, Hartford, at 4:00 P. M. The program will be as follows:

Business meeting.

"Doctor Looks At the Legislature," Dr. James R. Miller.

Dinner.

Musical selections, Mrs. Louis Spekter.

Symposium on "Medical Services During Wartime."

### Some of Replies to Christmas News Letter

54th Evacuation Hospital
APO 70
Postmaster, San Francisco, Cal.

Women of the Auxiliary, it was with a great deal of pleasure and interest that I read the Xmas News Letter you sent. This letter should become a habit and I am hoping you will compose a similar one at frequent intervals. For all I know these letters may have been published right along but this was the first that I have received. The medical fraternity is a very unique one in which there is a closeness one does not find among the members of other professions, and such a letter as this one serves to unify it even further. Please, continue them.

A very happy and successful New Year to you.

Sincerely
Gilbert E. Moore
(Residence—Darien) Capt., MC—AUS

Med. Det. 503 M.P.Bn
APO 403 c/o PM, N. Y. C.

This is to tell you that I enjoyed your Xmas News Letter. Please keep sending any of your letters to me. Please use the address given above.

Very sincerely
Myer Goldschmidt
(Residence—New Britain) Capt., MC—AUS

G.B. 94th Med. Gas Trt B.M.
APO 403, c/o PM, N. Y., N. Y.
Somewhere in France

I just received your News Letter which was sent to the States. You may be interested to know that I have been in the E.T.O. approximately 9 months and am attached to the Third Army. In the States we were activated as a Medical Gas Treatment Battalion, but now here we are functioning as an evacuation unit. Recently we received individually a campaign star for the first phase of the war in Europe.

Previous to joining the Army I was practising in East Haven, Conn.

I wish to thank you all for your News Letter.

Sincerely
Vincent Balletto
Capt., MC—AUS

Fourth General Hospital
APO 322, c/o Postmaster
San Francisco, California

I wish to thank you for your Xmas News Letter. If you publish a News Letter at intervals, I would like to receive it.

I am still in the South Pacific area. Am on duty on the dermatological service of the Fourth General Hospital, which is made up largely with doctors from a mid-western Medical School. The organization is the best one I have been with during 32 months overseas.

Rotation is slow here and practically a trickle. Many go on sick basis as they cannot stand the tropics, doctors included.

Sincerely yours
Alexander J. Mozzer
Capt., MC—AUS

## New Haven's Spring Tuberculosis Program

New Haven is this year planning a broad educational program on tuberculosis for the spring months. Under the leadership of Dr. Joseph I. Linde, health officer, and Dr. Clement Batelli, director of tuberculosis control, the Health Department plans to reach all sections of the community and as many organizations and groups as possible. Assisting with the plans are the Connecticut Tuberculosis Association, Employees Tuberculosis Relief Association and Yale University students of Public Health. The project will culminate in a mass x-ray program open to the community for a nominal fee. This will take place from April 30 through May 4 in the New Haven Health Department.

## Do You Envy Mississippi?

*The Mississippi Doctor* informs us that the State of Mississippi has one physician for every 2,500 people, that it has only 63 physicians under 35 years of age remaining in practice, and that 54 per cent of the physicians in that state are past 60 years of age.

Compare with this the figures from Connecticut where there is one physician for every 1,196 population, 114 physicians under 35 years of age in active practice, and only 17 per cent past the age of 65.

## Certain Principles for the Use of Vitamins

We are indebted to Julian M. Ruffin, M.D., in *Nutrition Reviews* for the following principles which "if intelligently followed will enable one to steer a safe course" in vitamin therapy:

1. Vitamin therapy is definitely indicated in patients having objective evidence of a deficiency state, but should always supplement dietary treatment, never replace it.

2. Vitamin therapy is useful in preventing the development of secondary deficiencies in chronic wasting diseases and pre and post operaitve medical care.

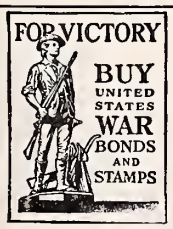
3. In the absence of organic disease, the individual who consumes a diet, adequate in calories, consisting of fruits, milk, eggs, a variety of meats, and green vegetables does not need additional vitamins.

4. Vague symptoms such as weakness, fatigability, insomnia, nervousness, and irritability, are more apt to be due to overwork, nervous tension, or to social, domestic, or financial difficulties than to a vitamin deficiency.

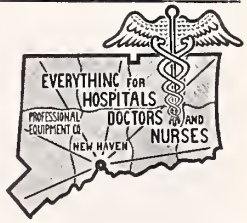
5. For the most part, prolonged vitamin therapy in the absence of obvious disease is useless.

## Prescription Costs

*Connecticut Pharmacist* informs us that only in the mountain states are the costs of filling prescriptions higher than in the New England states. No explanation is given.




THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# SPECIAL NOTICES

## APRIL PROGRAM OF ELEVENTH ANNUAL CONFERENCE TALKS 1945 Series

### at the Graduate Club of the Institute of Living

(The Neuro-Psychiatric Institute of the Hartford Retreat)

April 4—Physics and Technology in the Development of Physical Medicine. Francis O. Schmitt, PH.D., Professor of Biology and head of the Department of Biology and Biological Engineering, Massachusetts Institute of Technology; Member of scientific Advisory Committee to Baruch Committee on Physical Medicine.

April 11—Psychiatric Personnel of the Future. Lawrence S. Kubie, M.D., Associate in Neurology, College of Physicians and Surgeons, New York City; Faculty of New York Psychoanalytical Institute.

April 18—Practical and Flexible Psychoanalytical Techniques. Franz Alexander, M.D., Associate Professor of Psychiatry, University of Illinois Medical School; Director of the Institute of Psychoanalysis, Chicago; Attending Psychiatrist, Cook County Psychopathic Hospital, Chicago.

## STATE DEPARTMENT OF HEALTH OFFERS COURSES

The Connecticut State Department of Health announces a series of training and refresher courses in seriological tests for syphilis as follows:

May 14-18, 1945—Standard Kahn Test.

May 21-25—Mazzini Flocculation Test.

June 4-8.—Complement-Fixation Test.

June 11-15—Kline Diagnostic and Exclusion Tests.

June 18-22. Hinton Test.

Courses are open to serologists and technicians in Connecticut who have had some experience in performing tests for syphilis. Only a limited number of enrollees can be accommodated for each course.

Courses will be given at the Bureau of Laboratories, 1179 Main Street, Hartford, from 9:30 A. M. to 4:00 P. M. daily.

This is an opportunity for those who have not otherwise qualified to demonstrate eligibility for the certificate of approval which will be required for all persons doing tests for syphilis after June 1, 1945.

The State Department of Health is authorized to pay transportation and reasonable living expenses for all enrollees except those employed in private commercial laboratories.

Reservation for lodgings must be made by individuals. Recently a representative of the Y.M.C.A., 315 Pearl Street, Hartford, stated that usually rooms for men can be reserved in advance at rates ranging from $5 to $6 a week or from $1.25 to $1.50 a night. A representative of the Y.W.C.A. has suggested that if persons interested will write to the Young Women's Christian Association, 262 Ann Street, Hartford, the Association can assist in securing a room either in the Ann Street building or elsewhere in the city.

For registration and further details write to Friend Lee Mickle, SC.D., Director, Bureau of Laboratories, P. O. Box 1139, Hartford 1, or phone Hartford 7-6341.

## NOT CANCELED

The art contest sponsored by Mead Johnson & Company on the subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians) has *not* been canceled or postponed.

The closing date remains May 27, 1946.

There will be no annual exhibit *this year* of the American Physicians Art Association, due to the cancellation of the American Medical Association meeting which had been scheduled to take place in Philadelphia, June 18-22, 1945.

For full details regarding the $34,000 prizes and the "Courage and Devotion" contest, write Dr. Francis H. Redewill, Secretary, A. P. A. Association, Flood Building, San Francisco, Cal., or Mead Johnson & Co., Evansville, Ind.

## NUTRITION LABORATORY NOW IN CHICAGO

The Medical Nutrition Laboratory, formerly part of the Army Medical School, Army Medical Center, Washington, D. C., has moved to 1849 West Pershing Road, Chicago 9, Ill. Captain George Berryman, SnC, is the acting Commanding Officer and Captain Cyrus French, SnC, is Executive Officer. A new laboratory is being constructed and the scope of the work will be increased. In addition to training nutrition officers, there will be physiological, chemical and bacteriological studies made of nutritional problems pertaining to Army personnel.




**PROFESSIONAL HEADACHES:** — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.




(SEE PAGE 2)

# OUR NEIGHBORS

## Maine

Maine now has a new x-ray laboratory on wheels which will make it possible to increase its fight against tuberculosis. This photoroentgen x-ray unit is the newest weapon developed by medical science for mass chest surveys. It was purchased with state and federal funds. An unusual feature of Maine's unit is the installation of all x-ray and photoroentgen apparatus in such a fashion that it may be removed from the bus with relative ease and set up in a large school or factory where the number of people to be examined and the time involved would justify this method of conducting a survey.

## Massachusetts

On January 5, according to *The New England Journal of Medicine*, the failure of the Massachusetts Approving Authority to accredit the Middlesex University School of Medicine was upheld by the Superior Court of Suffolk County.

## New Jersey

The Medical-Surgical Plan of New Jersey during 1944 increased its enrollment from 16,015 to 30,427 persons. Its earned income during the same period rose from $74,498.17 to $187,708.74 and its operating expenses dropped from 23.9 per cent to 18.9 per cent. The annual hospital admission rate per 1,000 during 1944 was 91 and the average cost per claim, $61.22.

## New York

The Medical Society of the State of New York, as a contribution to the more vigorous prosecution of the war, has cancelled its annual meeting scheduled to be held at Buffalo, April 30—May 3. The meeting of the House of Delegates will be held unless further restrictions on travel are announced.

## Rhode Island

The Committee on War Conventions has granted permission for the Rhode Island Medical Society to hold its 134th annual scientific assembly at Providence on May 16 and 17. This was granted on the grounds that the Society uses its own medical library building for the session and no hotel or train facilities are involved. Medical personnel from military and naval installations located within that area are to participate.

Plans have been announced for a new and greater Rhode Island Hospital, calling for the expansion of this present outstanding community institution to become one of the finest equipped hospitals in the country. A new ten-story building accommodating 620 patients as well as housing modern laboratories and facilities will be erected on the site of the present main building.

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## U. S. Court of Appeals Rules War Vet, Doctor, Keeps Job

According to the *Journal of the Medical Society of the County of New York* the United States Circuit Court of Appeals for the Third District, in its first decision construing terms of the amendment to the Selective Service Act which requires employers to reinstate returned Veterans to their jobs, ruled recently that a medical director for an industrial corporation is an employee within the meaning of the law and entitled to his old job after discharge.

The unanimous decision written by Judge William H. Kirkpatrick orders the General Cable Corporation at Perth Amboy, N. J., to reinstate a Perth Amboy, N. J., physician as the company's medical director. The company refused to rehire him, claiming that he was an independent contractor rather than an employee; the employees' health association for which he had been medical examiner had engaged another physician and refused to take him back, and alleged that there would be "loss of efficiency" and "additional expense" if separate doctors were employed by the company and the employees' association.

Judge Kirkpatrick ruled that the law does not say that a returned Veteran must have been an employee, but is intended to protect the "status quo" of that Veteran in whatever position he held prior to his service in the armed forces of his country. As to the company's contention that there would be "loss of efficiency" and "additional expense" if separate doctors were employed by the company and the employees' association—the court held that such a claim, if upheld, "would defeat the main purpose of the act and limit its operation to merely capricious or arbitrary refusals."

## COUNTY ASSOCIATION ANNUAL MEETINGS

FAIRFIELD

Tuesday, April 10, 4:00 P. M.
Stratfield Hotel, Bridgeport
Speaker to be announced

HARTFORD

Tuesday, April 3, 4:30 P. M.
Hunt Memorial Building, Hartford
Speaker (following dinner at Hartford Club): George C. Adie, M.D., director of surgery, Grasslands Hospital, Valhalla and New Rochelle Hospital, New Rochelle, New York—"Some Present Day Problems of the Hospital and Staff"

LITCHFIELD

Tuesday, April 24
Place, speaker and subject to be announced

MIDDLESEX

Thursday, April 12, 4:30 P. M.
Edgewood Country Club, Cromwell
Speaker: Augustus S. Rose, M.D., instructor, Harvard Medical School—"The Treatment of Neurosyphilis by Penicillin"
Buffet supper

NEW HAVEN

Thursday, April 26, 4:00 P. M.
New Haven Medical Association Building, New Haven
Symposium on Industrial Rehabilitation led by Andrew S. Jackson, M.D., president of the Association, and Mr. Elton S. Wayland, vice-president, American Brass Company, Waterbury
Buffet supper

NEW LONDON

Thursday, April 5, 5:00 P. M.
Seaside Sanatorium, Waterford
Speaker (following dinner): Morris Tager, M.D., assistant professor of bacteriology, Yale University—"Tropical Diseases"

TOLLAND

Tuesday, April 17, 6:30 P. M.
Old Homestead Inn, Somers
Speaker: Ralph E. Kendall, M.D., pathologist, Hartford Hospital—"Blood Transfusions and the Rh Factor"

WINDHAM

Thursday, April 19, 1:00 P. M.
Nathan Hale Hotel, Willimantic
Speaker: A. N. Creadick, M.D., New Haven—"What the Cancer Drive Means to the Medical Profession"

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## New Medical Director for Metropolitan Life

Dr. Earl C. Bonnett, formerly Associate Medical Director of the Metropolitan Life Insurance Company, has been appointed Medical Director of the company by the Board of Directors, according to an announcement by Frederick H. Ecker, chairman of the board, and Leroy A. Lincoln, president. Dr. Bonnett succeeds the late Dr. Charles L. Christiernin, who died on October 18.

As head of the company's medical division, Dr. Bonnett will supervise a staff of about 8,000 physicians who serve as medical examiners for the Metropolitan in the United States and Canada. He will be responsible for the formulation of rules for the medical examination of applicants for insurance and advise in the establishment of rules for the selection of risks. His duties will also involve the management of Home Office health activities which include the medical care and periodical physical and dental examinations of some 14,000 employees.

Dr. Bonnett is a native of Provo, Utah. While a student at Cornell University, he enlisted in the Army in 1917, and served in the first World War as a private, sergeant and second lieutenant in the Field Artillery. He saw combat service with the 147th Field Artillery, 32d Division, A.E.F., in the Meuse-Argonne offensive.

In 1919, on returning from overseas service, Dr. Bonnett received the degree of A.B. from Cornell, and resumed the study of medicine, receiving the degree of M.D. from Cornell Medical College in 1923. He entered the service of the Metropolitan in 1926.

## Fairfield County Suffers First Casualty



LUTHER C. HEIDGER

Major Luther Caldwell Heidger, MC—AUS, Stratford, went down with the sinking of a Japanese prisoner ship in the South Pacific on September 7, 1944. We quote from a recent letter from a survivor of this ship: "In all the heat, sickness and lack of food, he continued his sick calls day and night, going around visiting the men and risking his life. He never lost control of himself, and worked sacrificially to carry out his duties as physician to the weak. I will never forget his figure standing up in the middle of the hold, with an old hat on his head, and chewing a ragged piece of cigar, I believe I will always consider him the finest doctor I have ever known."

Luther Caldwell Heidger was born in Philadelphia, Pennsylvania, on April 23, 1897. When he was a small boy, his family removed to Vermont, and for that reason he always considered that his home state.

His boyhood was spent on a farm in Greensboro, Vermont. Later he attended Muskingum College in New Concord, Ohio, and then returned to Vermont, where he graduated from the School of Medicine of the University of Vermont in 1921.

He interned in the Bridgeport Hospital, and practiced medicine in Stratford, Connecticut, until he entered active service. In 1929, he was appointed medical examiner of that town.

February 12, 1936, he was married in Greensboro to Bessie Cordiner Young, assistant superintendent of the Bridgeport Hospital.

Dr. Heidger entered active service on September 7, 1940, and his first assignment was at Fort H. G. Wright, New York, as medical officer of the 242nd Coast Artillery. In February 1941, at his request, he was transferred to Randolph Field, Texas, to take a flight surgeon's course. From there he was sent to Jacksonville, Florida, and later to Albuquerque, New Mexico, where he was assigned to the 19th Bombardment Group and promoted to Major.

This group went to the Philippines in October 1941, and was established at Clark Field at the time of Pearl Harbor. Without regard for his own safety, Major Heidger ministered to the men at Clark Field during the Japanese bombardment, and for this received the Distinguished Service Cross. He was also a recipient of the Air Medal with two citations for flying with a bomber group under hazardous conditions.

Since the time of Pearl Harbor, only two messages have come from him—one, a cable to his wife on December 17, 1941, and in September, 1943, a card from the prison camp at the Davao Penal Colony.

## Captain Crankshaw Killed in Action

Captain Orrin Crankshaw, a former member of the staff of the New Haven Hospital and of the faculty of the School of Medicine, was killed in action on the Western Front on February 23. Captain Crankshaw first came to New Haven Hospital as intern in 1935, and he progressed through to the rank of resident in medicine during the next three years. In 1938 he was named instructor in the Department of Internal Medicine which post he held for one year before starting private practice in Summit, N. J., in 1939. He went abroad with the Yale Medical Unit in November 1942 and later transferred to the Medical Corps. Captain Crankshaw is the first fatal military casualty among former medical school faculty members.

# NEWS
## *from County Associations*

### Hartford

Wendell C. Hall, after serving two years as a Major in the Army of the United States, has resumed his practice at 179 Allyn Street, Hartford.

At the annual meeting of ths Hartford Municipal Hospital held on March 13, Harry L. F. Locke was re-elected as chairman of the staff for his eighth year. Claude C. Kelly was re-elected vice-chairman and Samuel A. Donner, secretary.

Lt. Comdr. I. S. Geeter MC—USNR, New Britain, recently arrived somewhere in the Philippines. He is attached to a U. S. Fleet Hospital unit which is prepared to set up a large base hospital on one of the islands in the Pacific. His address is: U. S. Fleet Hospital No. 114, c/o FPO, San Francisco, Cal.

### Litchfield



Lieut. Roger S. Downs (MC) USNR

This photograph was obtained after publication of his obituary in The Journal March 1945, page 207

Lieut. Comdr. Edward H. Wray, MC—USNR, has been on the high seas for the past thirty-two months, fourteen months as a medical officer on a meat ship in the Atlantic and eighteen months on an OPA ship in the Pacific. He recently visited his home town on leave en route to a new assignment to the USNTS (WR), Hunter College, Bronx, N. Y.

### New Haven

Frederick Post and Frederick Wies have returned from overseas duty. Dr. Wies has spent his time in New Zealand with the 39th General Hospital and Dr. Post has spent some of his time there and the rest of his time in Bougainville and in the South Pacific.

They both are very happy to be home and extend their warmest regards to all the friends of the Yale Unit.

Clyde L. Deming of New Haven is the author of *Acute and Chronic Symptoms and Diagnosis of Movable Kidney* published in *The Pennsylvania Medical Journal*, December 1944. Dr. Deming read this paper before The Medical Society of the State of Pennsylvania at its 1944 session in Pittsburgh.

Arthur J. Geiger of New Haven is the author of *Health Services For Hospital Personnel: 1. A Neglected Branch of Industrial Medicine*, published in *The Yale Journal of Biology and Medicine*, January 1945. This paper was presented in part before the First Institute on Personnel Management of the American Hospital Association held at New Haven in June 1944.

Francis G. Blake of New Haven is the author of *The Therapeutic Indications of the Sulfonamides and Penicillin* published in *The Journal of the American Medical Association*, March 3, 1945. This paper was read in a panel discussion on "Chemotherapy" at the annual session of the A. M. A. in Chicago in 1944.

### New London

Albert G. Rapp, New London, has been retired to inactive duty status February 26, 1945 at Brooke General Hospital, San Antonio, Texas. He was on active duty two years seven months, MC—AUS. He served at the following posts: Camp Pickett, Virginia; Walter Reed Hospital, Washington, D. C.; New Orleans Port of Embarkation Hospital, New Orleans, La.; Brooke General Hospital, Fort Sam Houston, San Antonio, Texas.

Dr. Rapp entered the Army as 1st Lieutenant. At the time of retirement he held the rank of Major.

During his entire service he was in the EENT department of the above mentioned hospitals.

On March 20, Louis Harold Cohen left the Norwich State Hospital to enter the practice of psychiatry in New Haven. He will also teach psychiatry at the Yale Medical School with the rank of assistant clinical professor of medicine. His office will be located at 315 Whitney Avenue, New Haven.

Charles E. Clark, who had been serving on the Medical Staff of the Norwich State Hospital since July 15, 1944 in the capacity of assistant superintendent for the duration of the war emergency, has left the hospital to accept a permanent appointment on the staff of the New Mexico State Hospital, Las Vegas, New Mexico.

R. H. Guthrie, superintendent, Norwich State Hospital, has been appointed a member of Medical Advisory Board, No. 4 of Selective Service to examine recruits referred by the local Induction Boards in the district covered by Advisory Board No. 4.

The Submarine Base Dispensary, in reality a small well equipped hospital, provides medical, surgical, and dental care for all personnel attached to the Base; emergency care for civil employees; and outpatient department for dependents of service personnel. In addition, there is an Officer assigned for full time duty at the Dispensary in connection with problems in epidemiology, sanitation and industrial hygiene.

The various departments of this Dispensary include: surgical, medical, eye, ear, nose and throat, urological, x-ray, physiotherapy, physical examinations, pharmacy, laboratory, dental, family clinic and administration. Service dependents are hospitalized at the Lawrence and Memorial Associated Hospitals, New London.

The Wartime Graduate Medical meetings formerly held monthly at Fort Wright, Fishers Island, N. Y., are now conducted at the Submarine Base, New London. Although intended primarily for physicians stationed at Fort Wright and at the Submarine Base, these meetings are open to all physicians in New London county who may desire to avail themselves of refresher lectures. Due to the kindness of Captain M. D. Abbott the meetings are preceded by a dinner at 6:00 P. M. with the scientific program beginning at 8:00 P. M. Physicians from various localities of Connecticut have been conducting the programs of these important meetings.

# News from Yale University School of Medicine

Mayo R. Purple, who was an instructor in the department of medicine in 1941-42, lost his life on January 19 in the fire of the Hotel Bishop in New Haven.

# NEW BOOKS IN REVIEW

*MANUAL OF CLINICAL MYCOLOGY. By Norman F. Conant*, PH.D.; *Donald Stover Martin*, M.D.; *David Tillerson Smith*, M.D.; *Roger Denio Baker*, M.D., *and Jasper Lamar Callaway*, M.D., Duke University School of Medicine. *Philadelphia and London: W. B. Saunders Company.* 348 pp. 5½″ x7¾″, with 148 illustrations. $3.50.

Reviewed by MAURICE J. STRAUSS

Fungus infections are so prevalent that they should not be the field of interest of a few specialists, but deserve the attention of all physicians. The "Manual of Clinical Mycology" performs a great service in bringing to the practicing physician clearcut clinical descriptions and laboratory diagnosis. It clears up confusions in nomenclature and differential diagnosis of the mycotic infections and presents simplified classifications and methods. Treatment is modern and definitive.

The "Manual of Clinical Mycology" is well edited and abounds in epidemiological maps and descriptive plates. The plates of microscopic pathological sections are clearcut and show the organism well in tissue. The photographs of the lesions are of typical cases and should be of inestimable value to physicians unacquainted with fungus diseases.

Therefore, this volume is to be commended highly for its general and practical value to both the mycologist and the clinician.

*THE 1944 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY. Edited by J. P. Greenhill*, B.S., M.D., F.A.C.S., Professor of Gynecology, Cook County Graduate School of Medicine; Chairman, Deparmtent of Gynecology, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reeese Hospital; Associate Staff, Chicago Lying-in-Hospital; author of *Office Gynecology* and *Obstetrics in General Practice;* co-author of the DeLee-Greenhill *Principles and Practice of Obstetrics. Chicago: The Year Book Publishers.* 1945. 576 pp. $3.00.

Reviewed by STANLEY B. WELD

Connecticut physicians appear quite frequently in the 1944 Year Book. *Precision Methods in Cephalometry and Pelvi-*

*metry, Obliquely Ovate or Naegele Pelvis,* and *Clinical Significance of Midplane Pelvic Contraction* by Herbert Thoms of New Haven (the last in conjunction with Paul C. Schumacher) are all abstracted in this volume. Deborah C. Leary of Hartford has two articles appearing in abstract, each in conjunction with John P. Peters and the second also with P. H. Lavietes and A. W. Winkler, all of New Haven. They are *Intravenous Pyelograms in Normal and Abnormal Pregnancies* and *Diabetes Mellitus and Pregnancy.* Arthur H. Morse's paper on *Cancer of the Cervix in Pregnancy* is reviewed. P. D. Gibson's work on examining women in industry is commented upon by the author under the abstract of *Health Maintenance Program for Women in Industry* (M. R. Burnell, Flint, Michigan.) There is an abstract of *Preoperative Use of Testosterone Propionate As an Aid to Surgical Treatment of Endometriosis* by James R. Miller of Hartford.

The volume contains much of value in recent developments in obstetrics and gynecology. The Rh factor occupies several pages although all the articles published during the year are by no means included. As the author states, "the literature on this subject has increased enormously." John Rock's work on the human ovum is recorded. A discussion of the xenopus laevis test for pregnancy appears in several abstracts. The references to abortion contain one interesting review on the effect of travel. *Penicillin in Prevention and Treatment of Congenital Syphilis* is timely. The effect of parathyroid extract on pre-eclamptic toxemia is contributed by a physician in the State of Washington. Several pages are devoted to caudal anesthesia.

Belinkoff's work on cyclopropane-pituitrin incompatibility should be read by all obstetricians using these adjuncts. Early secondary repair of complete perineal tears is advocated by a British physician. In the abstracts on cesarean section, Howard C. Stearns' article on the extraperitoneal section is worthy of note. It is well illustrated. Chassar Moir of University of Oxford calls attention to the fallacies in soft tissue placentography. The question of early rising postpartum is discussed by C. F. Jorge and the editor.

In the field of gynecology, Walter W. Williams' work on sterility contains an excellent outline of the program and this is followed by several pages on the same subject. Several articles on ovarian tumors are abstracted and there is a section devoted to menstruation including an abstract on the use of hypnosis, one devoted to endocrinology and one to infections. The section on operative technic is relatively short.

As in previous years this edition of the Year Book affords an excellent reference volume for every physician practising obstetrics as well as for the specialist in obstetrics and gynecology. The editor's comments pursue the pattern of his predecessor, Dr. J. B. DeLee.

*SOLDIER TO CIVILIAN, PROBLEMS OF READJUSTMENT. By George K. Pratt,* M.D., Psychiatric Examiner, U. S. Armed Forces, Induction Center, New Haven, Connecticut: formerly Assistant Clinical Professor of Psychiatry, School of Medicine, Yale University. *New York: Whittlesey House.* 1944. 233 pp. $2.50.

(See JOURNAL, Vol. IX, No. 2, February 1945 for review.)


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Reviewed by JOSEPH O. COLLINS

The 4th Edition of this excellent book has been considerably revised and enlarged to include many newer methods. The authors have taken full advantage of collaboration with some 30 outstanding specialists in clinical pathology and allied fields. The book contains 1017 pages and in the table of contents are listed the following major headings: General Laboratory Methods, Clinical Pathological Methods, Bacteriological, Mycological and Virological Methods, Parasitological Methods, Serological Methods, Chemical Methods and Pathological Methods. Under these Major Headings some 45 pages of subheading are listed. This will give some notion of the comprehensive nature of the book. A bibliography follows each discussion.

Descriptions of procedures are clear and concise and there are many good illustrations. In many instances two or more techniques are described for a given test but for the most part a single "approved technic" is described under each heading. Thus many workers in the field may find some of their favorite techniques deleted and one may not always approve the particular method chosen by the authors. This, of course, is not necessarily any reflection upon the authors who, after all, have had a wealth of experience and have collaborated freely with many other experts in the compilation of the book.

Among the newer procedures included, to mention just a few, are the copper sulphate method for blood and plasma specific gravity, hemoglobin and protein; Hangars Cephalin-Cholesterol Flocculation test of liver function; methods for various vitamin determinations; and methods for bio-assay of estrogens androgens and prolan. The reviewer failed to find any reference to the significance of variations in 17 ketosteroid content of the urine or any method for its estimation. Methods for typing influenza bacilli are included and also methods for determining adequacy of serum therapy in influenzal meningitis. There is a good description of the photoelectric colorimeter and many of the chemical methods outlined are adapted both to the plunger type colorimeter and to the newer photoelectric apparatus. Suitable methods for operation of a blood bank and for the processing and storage of plasma are described. Footnotes indicate where materials for performing many of the newer technics can be procured. Considerable attention is given to epizootic diseases and their study by laboratory methods.

With the amount of attention being given to the develop-



EPHRAIM CUTTER, M.D.
B. circa 1830

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ment of newer laboratory methods, any text book on the subject runs the risk of being out-dated the minute it comes off the press. Nevertheless Kolmer and Boerner's "Approved Laboratory Technic" is for the moment quite up-to-date and will remain for many years to come an important reference book on the subject. It should be in the reference library of every clinical pathologist and should be readily accessible to every clinical laboratory technician.

*CLINICAL HEART DISEASE.* (New Third Edition.) *By* Samuel Levine, M.D., F.A.C.P., Assistant Professor of Medicine, Harvard Medical School; Physician, the Peter Bent Brigham Hospital, Boston; Consultant Cardiologist, Newton Hospital; Physician, New England Baptist Hospital. Boston. *Phialdelphia and London: W. B. Saunders Co.* 1945. 462 pp. Illustrated. $6.00.

Reviewed by PETER J. STEINCROHN

In keeping with all recently published books, the war format of *Clinical Heart Disease* necessitates smaller print and narrower margins, yet these minor inconveniences are neutralized by its compactness and consequent easy handling in its present form.

There are 954 electrocardiograms, many of which are new. In addition to the usual discussions of disease found in most books on cardiology, there are practical chapters on Acute Cardiovascular Emergencies, Medicolegal Aspects of Heart Disease, The Clinical Significance of the Systolic Murmur, The Patient with Heart Disease as a Surgical or Obstetrical Risk, Factors Concerning Prognosis, and the Nature and Treatment of Congestive Heart Failure.

New major additions are devoted to a consideration of scleroderma heart, rupture of valves, the heart in Addison's disease, surgery in the treatment of patent ductus arteriosus and the use of the new chemotherapy in the treatment of subacute bacterial endocarditis.

Those who have heard Dr. Levine speak, yet have never read his well known book, will experience a delightful satisfaction in the reading of it. They will come away from it with the realization that what they have learned has been imparted by a unique breed of teacher, whose mastery of the lecture platform is equalled (if not surpassed) by his written word. Dr. Levine writes as he talks, he excites the reader's curiosity—and then satisfies it.

The new edition of *Clinical Heart Disease* wears well. Almost ten years have passed since the book was published, yet it is as fresh, stimulating, and instructive as when first presented to the medical profession. It deserves its popularity.

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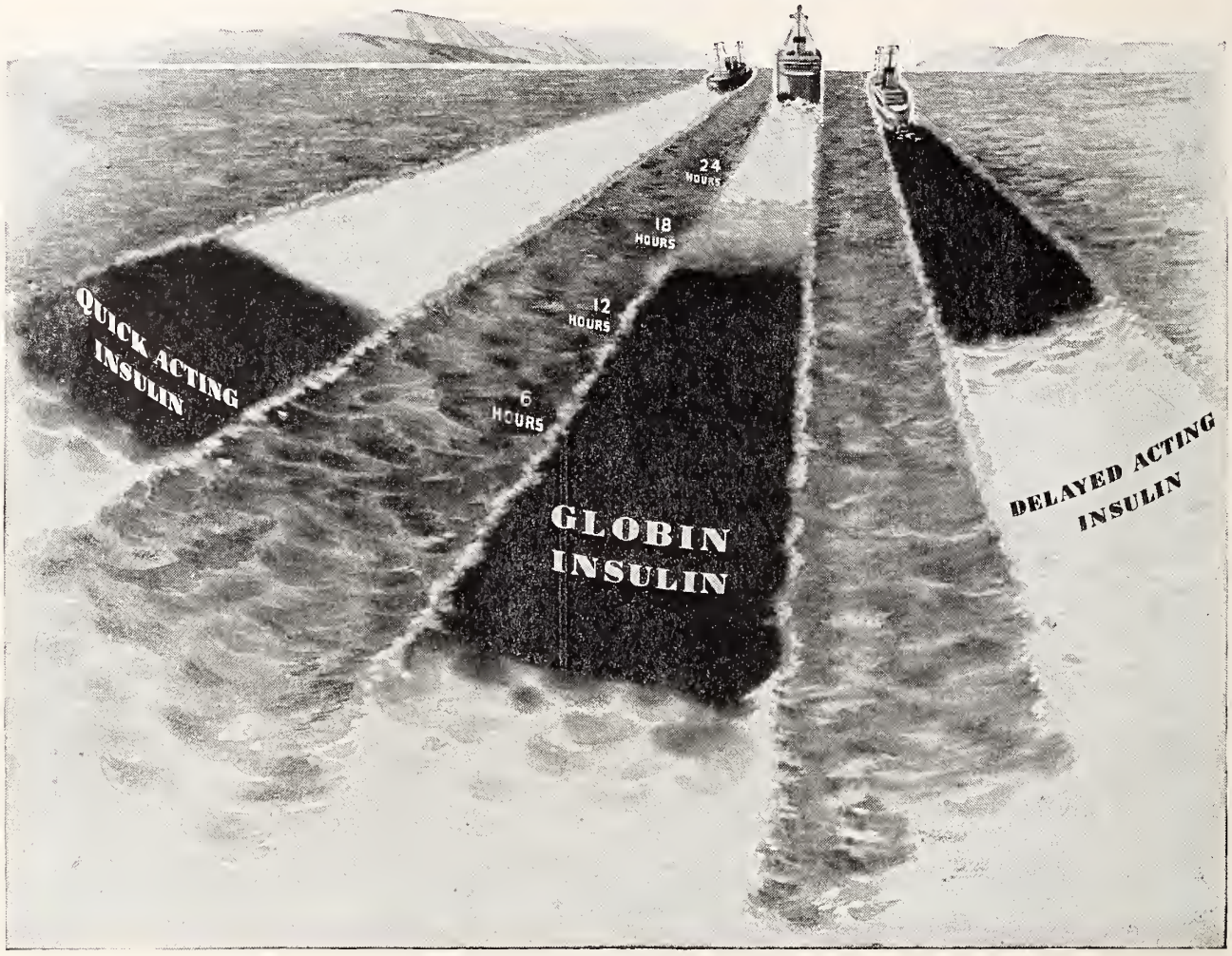
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OL. IX MAY, 1945 No. 5

# FUNDAMENTAL CONCEPTS IN THE DIAGNOSIS AND TREATMENT OF EARLY AND LIMITED TUBERCULOSIS

J. Burns Amberson, M.D., *New York*

The Author. *Professor of Medicine, Columbia University, College of Physicians and Surgeons, and Visiting Physician in Charge, Chest Service, Bellevue Hospital*

The impressive thing about the trend of tuberculosis in the United States is the reduction of mortality to a figure which today is 20 per cent of that prevailing in the early part of the century. Without doubt the techniques of public health and clinical practice share a large part of the credit for this decline which, happily, still continues. But there is still a grim side of the picture which confronts one who stands at the bedside of the patient with advanced tuberculosis and contemplates the wide implications of this tragic and avoidable situation. In many countries of the world tuberculosis remains the most serious of all diseases; in our own country it is still the most threatening, disabling and fatal among those who are entering adolescence and early adult life. In spite of the hue and cry for early treatment, more than 90 per cent of tuberculous patients entering the hospitals and sanatoria of most communities have moderately advanced or far advanced disease. The improvement in treatment of these institutionalized patients has been great, and anyone with experience can point to many whose lives have been prolonged and made bearable and useful by the newer methods. Yet there is the obverse of the picture disclosing that the death rate in hospitals and sanatoria is 19 per 100 per year, almost precisely the same as it was in 1925 (Drolet). Remembering that most patients coming for treatment have cavitary tuberculosis with positive sputum, one can brood but darkly over Thompson's late report of a study of 406 sputum-positive cases in an English industrial area which repeats the same old story that only one in four patients survived five years, and scarcely half of the survivors lasted out the next five. Such observations, if contemplated too narrowly, blanket the victims in gloom like that of generations past, when the consumptive could meet his destiny only with resignation, fatalism and a change of climate. That this need not be so is now well beyond question, since the possibility of discovering tuberculosis in its earlier stages has been so amply demonstrated. Wherever diagnostic surveys have been conducted for this purpose, the percentage of lesions revealed in early and limited stages has varied from 70 upward, a complete reversal of the situation which prevailed previously. Such surveys, using the x-ray as the first diagnostic screen, have revealed about 2 per cent of the population harboring pulmonary tuberculosis which is readily demonstrable. This has raised a great many questions touching public health, economics, social welfare and legislation. Obviously, all these as well as the strictly medical aspects hinge on an interpretation of the meaning of the discovered lesions. Are these identical in structure and potentiality with those discovered by Bayle, Naegeli, Burkhardt and many others at autopsy in the lungs of most adults, therefore usually innocuous and undeserving of the attention of the clinician, or are they precursors of destructive tuberculosis which so often is fatal Here indeed is the core of a problem which is vital not only for the individual bearing the lesion, but also for the replanning and perfection of the campaign to control and virtually eradicate the disease.

The problem may with profit be approached from the background of past experience with advanced disease. This much is beyond debate. About 90 per

*Annual lecture sponsored by the Phi Delta Epsilon Fraternity at Yale University, School of Medicine, January 31, 1945*

cent of all serious and fatal tuberculosis is pulmonary and most of the disability and deaths occur after puberty. Progressive pulmonary disease is very uncommon in children and its appearance is usually detected first between early adolescence and the ages of thirty or thirty-five. It can hardly be said that one is safe against acquiring pulmonary tuberculosis after thirty or thirty-five if he has not developed it previously, but the chances are certainly against it, and, by the same token, it is evident that much or most of the tuberculosis of elderly people dates back to lesions which were present and could have been diagnosed in adolescence or early adult life. To reflect still further, it is well known that most advanced pulmonary tuberculosis is the result of a series of extensions of the infection in the lungs from a lesion which originally was small, could have been diagnosed, and probably would have healed under proper treatment. Likewise, most of the complications, such as tuberculosis of the larynx and of the intestine, are traceable to a similar source. The only difference is that in the first case the bacillus, escaping from an ulcer or cavity in the lung and while being transported in mucopus through the bronchial tree, was aspirated into healthy alveoli, while in the latter, it was carried on to contaminate and infect the larynx, or was swallowed and farther on contaminated and infected the intestine. These fundamental mechanisms need repeated emphasis. It is a clinical truism that tuberculosis of the larynx is seldom traceable to infection by way of the lymph or blood stream and that it rarely appears until a cavity develops in the lung; similarly, that, while tuberculosis of the peritoneum may be readily ascribable to dissemination of the infection by way of the blood stream, ulcerative disease of the intestinal mucosa usually is not observed until after the pulmonary cavity has appeared and tubercle bacilli are demonstrable in the sputum: the inferences are clear. In the lungs, these so-called bronchogenic or transbronchial disseminations or spreads of the infection are familiar in great variety, ranging from acute episodes, sometimes with rapidly fatal outcome, to slowly progressive or intermittent occurrences which locally may be accompanied or interrupted by reparative processes such as resolution and fibrosis. Yet we observe that most adults have inhaled the tubercle bacillus and harbor in their bodies tubercles which heal locally and do not materially affect health. Usually the tubercles are too small to be demonstrated in the living subject and their presence can only be inferred because of the capacity of the tissues to react on contact wi tuberculin. Obviously, therefore, the task is n merely to detect the presence of tubercle but, as part of the diagnosis, to analyze all identifiable fa tors so as to distinguish those lesions which threat to advance and therefore must be treated from tho which have become self limited and arrested and not necessitate any change in the life of the patie At best this is difficult. Even to approximate accu acy requires most careful observation.

To consider first the detection of pulmona lesions it is now well known that these are discover most often by roentgenograms, that the older clas cal methods of physical examination are not diagnc tic in most cases, that the patient frequently fe and acts as a perfectly healthy person, and th incidental guides such as the hemogram, the sed mentation rate of the erythrocytes, and the examin tion of the sputum may be entirely norm Frequently; therefore, one is left with the roen genographic shadow as the only evidence pathology. (Obviously the matter of first impor ance is to determine whether the lesion is tuberc lous or of some other nature, but it is not my purpo to go into principles of differential diagnosis.)

Since the x-ray shadow in most cases affords th closest approach to the extent and the morpholog of the lesion, all possible information should b sought from this source. Many of the lesions are ver small and they may easily be obscured by th shadows of soft tissues or more dense structure such as the ribs, in which case better visualizatio may be had by oblique exposures or by directin the central x-rays at an angle above or below th usual level. Laminagraphs usually are of little hel since much desired detail is lost. It is important t select the proper exposure since variation towar over-penetration or the reverse may prevent max mum visualization. The smaller the lesion, the greate is the technical difficulty; the same is true of so lesions and these are the most important. Som minute, fresh and dangerous lesions are indistinguish able until they attain a size of several millimeters o even larger. Assuming that the shadow is visible wit some clarity, certain features may be more or les identified to indicate its anatomical significanc Thus, a dense, very sharply circumscribed sma round nodular shadow points toward a lesion whic is confined or encapsulated. On the other hand, soft mottled or feathery shadow speaks for a recen or active inflammatory process which in all probabil ity is unstable and liable soon to change for bette

r worse. One cannot pretend to be able to interpret hese shadows in terms of exact pathology but at east the aim should be in that direction, bearing in nind the potential meaning of lesions of different tructure.

Evidence indicates that most small nodular lesions ecome well encapsulated and durably healed. 3y contrast, the small inflammatory lesion is to e considered as a patch of tuberculous pneumonia vith many more potential implications. It is a more abile lesion, likely to resolve in part or else to under-o central caseation with relative rapidity. Central iquefaction and ulceration into the bronchioles ccurs more often and sooner than in the case of the roliferative tubercle. Since tuberculosis advances hrough the lungs usually by contiguity and by ransbronchial dissemination of the infection from ne of these small preexisting lesions, consideration f influential factors is necessary. In children lym-hatic extension to the hilar nodes from a primary focus in the lung is the rule, but in adolescence and dult life our experience is that this is much less frequent and usually of minor importance; following he primary infection it is very exceptional to detect enlargement of the hilar nodes, and when this is oticed it is more likely to be in a Negro than in a white person.

When roentgenographic evidence of transbron-chial dissemniation is indicated by the appearance of new mottled shadows in the pulmonary fields, the presence of an ulcerative focus, usually a cavity, can e inferred even if it is not readily demonstrable. Tubercle bacilli are practically always found on examination of the bronchial discharges. Without ulceration such transbronchial extensions do not ccur and the diagnosis of tuberculosis, therefore, may be questioned. Conversely, it may be said that nce ulceration has occurred, transbronchial spread, erhaps of a very local and minor character, is almost nevitable. As stated, the variety of the secondary esions is great. They may be small, demonstrable nly in the roentgenogram, and completely symp-omless. At the other extreme, they may be exten-ive, confluent, and clinically hyperacute, appearing s a florid tuberculous pneumonia. Generally speak-ng, conditions which favor rapid caseation, lique-faction and ulceration, also favor serious transbron-chial extensions. Stated more specifically, an acutely nflammatory lobular lesion is likely to caseate and slough rapidly and to be the source of serious exten-sions. Once the cavity has formed, the severity and frequency of subsequent spreads is determined somewhat by the character of its wall. Obviously if this consists of an actively caseous necrotic mem-brane, exudation from it is greater and numerous tubercle bacilli are cast off. The charge of the infec-tion entering the bronchial tree is relatively large and the menace, therefore, great. Conversely, if necrosis has subsided and the cavity wall has become transformed by granulation and fibrous tissue, drain-age is less and the dose of infection not as dangerous.

The probability of transbronchial dissemination depends also to a considerable extent upon the physical properties of the discharge in which the bacilli are transported. If the quantity is not great and consists largely of mucopus, the viscid, clinging, coherent character of this vehicle permits effectual transportation through and elimination from the bronchi and trachea, but if the medium is very fluid and thin, as, for example, during hemorrhage, the discharge runs freely into the finer branches of the bronchi and even into the alveoli where tubercle bacilli may be quickly transported and implanted, resulting in new lesions. Similarly, if a patient with a small discharging tuberculous focus is given an anesthetic which produces much bronchorrhea, as ether may do for instance, this excessive flow of fluid may carry the organisms into healthy paren-chyma, accounting for the postoperative reactiva-tion of the tuberculosis. A common cold with catarrhal inflammation of the bronchial mucosa may act somewhat in a similar way. Mechanisms of this kind help explain many clinical phenomena. For instance, a patient with a small fibrous cavity and a persistently positive sputum may go for fifteen or twenty years without any evidence of a broncho-genic extension. On inquiry, he usually gives the information that he raises his sputum in the morning as a thick nummular globule which has the appear-ance of mucus containing a few flecks of pus. Then, following a hemoptysis, the first evidence of exten-sion of the disease may be noted.

Such physical factors also help determine the character of secondary lesions. If purulent exudate draining from a cavity is aspirated into a dependent segment of the lung, an inflammatory confluent lesion often results, the inference being that a con-centrated dose of tubercle bacilli is accountable. One of the best examples is the rupture of a tuberculous abscess containing liquid pus; presumably millions of tubercle bacilli are suddenly liberated and the liquid vehicle is easily inhaled deeply into the alveoli. The result clinically then may be an acute tubercu-lous pneumonia, asserting itself within twenty-four

to forty-eight hours. On the other hand, a copious hemorrhage from a fibroid cavity may carry tubercle bacilli only in great dilution. The aspirated blood may carry relatively few tubercle bacilli here and there into widely separated parenchymal segments, and the result may be the development of widely scattered small tubercles or lobular pneumonic lesions which have been designated, not too exactly, "bronchogenic miliary tuberculosis."

A study of aspirational mechanisms in a variety of conditions including tuberculosis, lung abscess, lipid pneumonia, etc., reveals such predisposing factors as emphysema, depression of the protective reflexes and general influences such as unconsciousness. The inelastic emphysematous lung is a poor bellows and does not empty itself of foreign material very readily. The failure may be more pronounced if there is an alteration of the bronchial mucosa and a loss of ciliated epithelium. Patients who do not gag in response to irritation of the pharynx, aspirate secretions from the mouth and upper respiratory tract somewhat easily, and one may suppose that a similar impairment of the sensory reflexes of the trachea and major bronchi will favor the aspiration of tuberculous pus from a cavity. Unconsciousness or stupor from any cause may permit the aspiration of infectious material leading to the production of a lung abscess; by the same token, one acquires the clinical impression that transbronchial dissemination of tuberculous infection occurs more readily under such conditions, even during sleep. The implication of all this may be reflected in the old emphysematous tuberculous patient whose protective reflexes are poor and who sleeps deeply; here it is common to see a slow relentless advancement of the disease.

The direction of the transbronchial spread determines the location of the new lesions. As would be expected, these are seen most often in the vicinity of the cavity but, commonly enough, they appear in some distant segment. For instance, a cavity in the left lung often gives rise to new disease in the right, the site of predilection being the lower part of the right upper lobe. Years ago Aschoff offered the explanation that the bronchus of the right upper lobe takes off from the trachea in a manner which makes it easily accessible for an aspirational process. While the patient lies sleeping on his right side, it is easily seen how the orifice of this bronchus may act as a catch basin for fluid gravitating into the trachea. During a hemoptysis most patients seek the bed and lie in a recumbent or semirecumbent position. Infection then is most readily transported into the lower lobe bronchi and posthemorrhagic tuberculous pneumonia is likely to be seen there. Should the patient start bleeding while walking the street, he would bend over and expectorate into the gutter; consequently, if a bronchogenic spread occurs, it may be seen mostly in the lingula of the left upper lobe or in the right middle lobe.

A knowledge of these factors would be of little practical value except as it may enable the physician in his analysis of the case to visualize potential events and to take steps to avoid them.

The first lesion of clinical significance to be revealed by the roentgenogram usually is single, small, soft, and confined to one lung, but there may also be questionable changes or definite small, irregular or nodular densities near the apex. The inference then is that the major lesion may actually be the result of a bronchogenic extension from a preexisting minute focus, usually apical, which may have been present for years. The mechanism of ulceration and transbronchial spread may be precisely the same as in the case of the easily demonstrable cavity, the only difference being one of degree. A microscopic tubercle may caseate and break into a bronchiole producing a microscopic ulcer and a small secondary lesion, and none of these changes except the last may be visible by x-ray, though an exhaustive search of the sputum or gastric contents may reveal tubercle bacilli. In any event, when a number of separate lesions are discovered scattered irregularly in the lungs, the assumption is usually justified that these are the result of recent or old transbronchial disseminations.

The small early lobular pneumonic lesion is most frequently situated near the surface of the lung, commonly in an upper posterior segment. As mentioned, it may be impossible to elicit rales but a special effort should always be made to do so. In clinical records it is often noted that rales are heard by some observers and not by others. This is more often due to differing technique than to variations in physical conditions. The proper technique to bring out rales is generally taught but frequently neglected. The purpose of using the expiratory cough is to expel the maximum amount of gas from alveoli and bronchioles so that the succeeding current of suddenly inspired air rushing through the moist passages may generate audible bubbles and vibrations. This explains why the use of a quick succession of expiratory coughs may bring out rales which a single cough does not. Eliciting rales is of value not only for diagnosis but also for pathologic

nformation. While there are many exceptions which nave to be interpreted in the individual case, it is generally observed that the more moist, the larger and more easily audible the rales, the more likely is the lesion to be undergoing necrosis, liquefaction and ulceration. Many times rales can be interpreted to suggest excavation when all the classical signs of cavity are lacking.

Minimal pulmonary lesions as a rule do not give rise to a quantity of sputum greater than one or two cubic centimeters; more often the patient reports there is none. Since small bronchial discharges carrying tubercle bacilli may be swept into the throat by ciliary action and swallowed unconsciously, it may be necessary to obtain the contents of the fasting stomach in the early morning for concentration and examination. This depends a good deal on the patient's ability to collect small quantities of expectoration. The success of laboratories in demonstrating tubercle bacilli in specimens of sputum or gastric contents varies widely. The laboratories of good sanatoria are more efficient in this respect than those in most general hospitals. There are certain niceties of technique which the experienced technician employs to great advantage, not only in microscopic examination but also in cultivating the organisms on artificial media or in inoculating guinea pigs.

An observation of value which frequently is completely neglected is that of noting the gross physical characteristics of the sputum. Assuming that tubercle bacilli are demonstrable, a thin, greenish, purulent sputum is suggestive of an actively caseating ulcerative lesion. As this changes to a mucoid discharge containing small flecks of white or yellow pus, it may be assumed that active necrosis is subsiding. Purulent sputum issuing from a tuberculous lesion practically always contains tubercle bacilli. If suitable examination fails to reveal them, particularly if the sputum amounts to more than several cubic centimeters and is definitely purulent, the presumption is that the lesion is not tuberculous.

Frequently enough, only a very few tubercle bacilli can be discovered and the meaning of this must be interpreted. Taken alone it may indicate an old fibroid lesion containing a small cavity which discharges chronically, or a recent potentially dangerous inflammatory focus which is just beginning to break down and slough its contents into the bronchial tree. In the latter event the danger of transbronchial dissemination is greater.

Bleeding from a newly developed tuberculous lesion does not occur until it has undergone caseation and liquefaction and has established an ulcerative communication with the bronchus. Therefore, hemoptysis in the presence of a parenchymal lesion is presumptive evidence of ulceration and excavation and, by the same token, tubercle bacilli should be demonstrable in the expectoration. The greater danger of transbronchial dissemination during bleeding is always to be considered as described above.

While the absence of subjective symptoms frequently leaves one without supporting evidence in cases with apparently active early tuberculosis, the presumption of good health should not be accepted too readily. The toxemia of tuberculosis is peculiarly mild, and patients usually do not feel badly, even when febrile. The languor, easy fatigue and loss of weight are usually assumed to be due to the wear and tear of life. The same may be true of slight tachycardia. The absence of fever is more the rule than the exception in early active tuberculosis. In a few cases with a limited lesion, pleuritis pain may occur at the same level. In a minority pleural crepitus or coarse friction may be heard at the site of the pain, indicating an active inflammation of the pleura which in turn is to be interpreted usually as indicating an active process also in the lung beneath.

Remembering the pattern of dissemination of tuberculous infection, particular attention is given to symptoms which may accompany some secondary focus. Early involvement of the larynx, even when the pulmonary cavity is not large, is not rare. When the patient complains of dryness of the throat and huskiness of the voice, and examination shows local inflammation in the posterior parts of the vocal cords or in the arytenoid region, or a diffuse redness and edema, the probability is that this is early tuberculosis of the larynx, and therefore that tubercle bacilli should be present in the expectoration, and in turn, that ulceration of the pulmonary lesion has occurred.

At the start of pulmonary tuberculosis the hemogram and erythrocyte sedimentation rate are usually normal. Many patients develop the disease and recover, never experiencing such manifestations of toxemia.

The intensity of the reaction of the skin to tuberculin usually is not helpful in deciding the dynamic status of the lesion, except that it may diminish greatly in some cases after small lesions have become well encapsulated. A fresh pulmonary lesion appearing within six months or a year after the tuberculin

test first became positive is likely to be very unstable and menacing. The vexed question whether tuberculin allergy is a help or a hazard could be discussed at length. Suffice it to say that, while allergy asserts itself within a few weeks after the first infection, specific relative immunity develops slowly and does not seem to reach its height for several years. To be aphoristic, one might say that allergy comes but immunity lingers. Sanatorium patients often say that the first two years are the hardest, which is not a fallacious observation. Specific relative immunity, when developed, seems to have a protective value against reinfection and to enhance resistance against tubercle which is already present. If relative immunity is low, this tissue hypersensitivity may be deleterious. It seems to me to sum up about as follows: If the initial infection is small, the resulting lesion is likely to be limited by the natural defenses of the body and held in abeyance. Barring serious repetition of infection specific relative immunity may gradually increase and contribute to permanent healing of the lesion. On the contrary, if the initial infection is massive, the natural defenses may be inadequate; there is local evolution and necrosis, and even though some healing occurs later, there are, at best, encapsulated caseous residues which harbor tubercle bacilli and are a menace for years to come. In either event allergy develops at about the same time. It would seem, therefore, that the quantity of tubercle bacilli inhaled and the adequacy of native resistance are of more immediate importance than allergy or acquired immunity.

Having explored the characteristics of the disease, one must also consider the characteristics of the patient or, as Osler would say, the soil. Age is a most important factor indicated by the mere fact that serious tuberculosis usually does not develop until after puberty. Adolescent patients notoriously do not withstand tuberculosis as well as their elders and this is a little more true of girls than boys. A soft lesion, even if only one or two centimeters in diameter, showing in the roentgenogram of an adolescent boy or girl, is always a serious menace and the odds are in favor of extension, necrosis, ulceration, and dissemination unless treatment is given, and sometimes in spite of treatment. If it is known from serial examinations that the lesion is new, this conviction is even more justified. As stated before, tuberculosis in the elderly frequently had its origin in the early infiltrates of adolescence or young adult life. Older people, therefore, are seen more often to have lesions which have already undergone more or less healing by the time the diagnosis has been made. Time has elapsed to permit building up some specific relative immunity. Nevertheless, there is a sex difference of practical significance, since in many or most communities three or four old men die from tuberculosis to every old woman.

The factor of race, contrasting Negroes with whites, compels the assumption that the former do not have as adequate a resistance against the disease. There is a greater tendency among Negroes to progressive caseous tuberculosis and to generalized dissemination. In adolescence and early adult life the death rate from tuberculosis in New York City is twenty to thirty times as high in Negroes as in whites. This of course indicates the necessity of taking a more cautious view of early lesions among Negroes, particularly among the young, and planning treatment accordingly.

It may seem superfluous to emphasize the necessity of considering environmental factors such as domestic stress, the economic status, and the occupational conditions in which the patient is living. The physician cannot possibly approach the problem of management of the individual case without considering the relative importance of these factors. It is a time consuming task to ascertain and evaluate them, but well worth while; it is the patient's future and not the doctor's time which is most important. If he does not have time for this, he should not presume to treat tuberculosis.

In forming a judgment about the management of the individual case, experience may clash with statistics. Some will say that encapsulated tuberculous lesions are found in most human cadavers and, therefore, that nature usually looks after small lesions. This undoubtedly is true in a superficial way, but in considering the potentialities and the needs of a young girl with an early lobular pneumonic tuberculus lesion, such oobservations form only a hazy background. Evaluation of the case as a strictly individual problem, weighing all identifiable factors, is indispensable. The practice is to be decried of peering at an x-ray film and deciding from this alone what adjustment, if any, the patient should make. Brooks, in a considerable experience with tuberculosis discovered among the personnel of the British Royal Navy, takes the reasonable and sound point of view that out-patient or dispensary supervision unaccompanied by investigation in hospital is quite inadequate. He favors an investigation in a hospital to evaluate minimal lesions and found the mean period occupied by the examination was ten days. The

eneral adoption of this principle in the evaluation f all discovered cases would be sound and constructive.

To take the point of view that these patients need othing more than periodic x-ray examination, that nost of these infiltrates will heal without treatment, nd that treatment is not necessary until and unless he lesions have undergone necrotic and destructive hanges, probably with dissemination of the infection, seems to me entirely unwarranted by the evidence. The rare opportunity to institute treatment, promising an actual cure, is the time before the first phase of advanced tuberculosis has asserted itself. That fine discriminations must be attempted and made is necessary and reasonable, considering the vital importance to the patient. To illustrate the principles involved, a few examples may be cited.

Lesions discovered in the roentgenogram, usually in middle aged or elderly people, which have a hard nodular appearance, are usually a centimeter or less in diameter, and only single or few in number, can be assumed to be old and encapsulated, and, if dense at the center, to be more or less calcified. Usually there is no impairment of health and the examinations show no deviations from normal except that a few rales may be heard at the level of the lesions. Since rales may be audible after healing is adequate and for the remainder of the patient's life, it may be good judgment to disregard them. Such patients then require no treatment but it is good sense to advise an annual examination including a roentgenogram. Limited lesions which are fibroid but not necessarily nodular, must be studied to determine if the appearance from x-ray and physical examination really justifies the assumption of sufficient fibrosis and dependable stability, and whether there is any cavity present within the fibroid changes. Exhaustive searches for tubercle bacilli are most important. If bacilli are not found, these cases belong to the same category as the nodular lesions but they are a little less safe, particularly if the patient is in his twenties or thirties. It is wise to reexamine at least every three months to make sure that stability is durable.

Limited fibrocavernous lesions in which the cavity is usually small and apical are often found to represent tuberculosis in which healing has been significant but incomplete. Except for a morning cough the patient may be quite well; expectoration contains tubercle bacilli and there is a considerable chance of transbronchial dissemination and serious clinical symptoms sooner or later. Some small cavities of this type will heal under rest treatment, but, if not, these are the cases in which a limited thoracoplasty designed to collapse the diseases area is most suitable. This may close the cavity, confine the disease, and, if the patient is young, save him from recurrent illness or chronic disability. Old people are usually better off to accept the inevitable and lead a carefully regulated life under proper medical supervision, observing precautions to avoid infecting others.

The small lobular pneumonic lesion of similar extent, found most often in young people, is of very different meaning and deserves different consideration, and this is particularly true if a small cavity is present. This so called early infiltrate represents at one time a serious menace to the patient's health and a rare opportunity for effective treatment. The x-ray shadow has been mentioned. Most of these patients report no sputum but an efficient collection and search of the sputum or gastric contents by microscopic and cultural methods reveals tubercle bacilli in a great majority. Stiehm found the organisms in 72 per cent of 50 cases among students at the University of Wisconsin. Medlar found them in 83 per cent of 53 minimal cases in which the lesions appeared unstable in the roentgenogram. These lesions are not often seen at autopsy but, if so, they are practically always found to be somewhat caseous. Since the presence of tubercle bacilli in the expectoration means ulceration, a reasonable inference is that when a soft lesion, even though minimal, is large enough to be visualized by x-ray, it can be assumed to be necrotic at the center, usually ulcerative and a fertile source for transbronchial dissemination. If the patient is young, and particularly if he is a Negro, this tendency is all the stronger. These are not the small foci discovered at autopsy at the apex in patients dying from other causes. There is no good evidence to show that these diagnosable soft lesions usually heal without treatment, and what evidence I have been able to discover indicates that, if neglected, most of them progress.

The rate of evolution of these unstable lesions, particularly in young people, is extremely variable, emphasizing the necessity of close and continued observation in a hospital until the trend is determined and effective treatment is established. There is still too much of a tendency always to regard tuberculosis as a chronic disease if there are no symptoms. On the contrary, the lesions may become

confluent, necrotic, progressive, and extremely serious during an interval of a few days or several weeks before subjective symptoms declare themselves. The collection of objective evidence is essential to comprehend not only the immediate potentialities of the case but also the prognosis during the rest of the patient's life. One should consider the possibility of early symptomless progression and should not be deceived by latency simulating healing. By x-ray the lesion may show little or no change during weeks or months; meanwhile its center may be undergoing slow caseation and liquefaction up to the point of ulceration when dissemination may occur abruptly. The latent period may last even for many years, while the caseous center of the lesion may be confined by fibrosis. Late excavation then may be observed with a clinical relapse. It is clear therefore that treatment which leads to healing of a local lesion without the encapsulation and retention of caseous matter harboring tubercle bacilli is to be desired. This is approximated only by healing before much necrosis has occurred or by healing after the necrotic center has been sloughed out. Obviously, the former is preferable since the possibility of transbronchial dissemination is thus minimized. It is often true, therefore, that the early evolution of a lesion toward resolution or toward caseous necrosis largely determines the ultimate course of the disease; and this lends support to the view that proper treatment in the first few weeks may be more important than anything done afterwards.

Unfortunately the mechanisms leading to healing of inflammatory tuberculous lesions, while apparently similar to or identical with mechanisms operating in inflammatory lesions of all sorts, are not too well known. Experience teaches that rest often leads to an abatement of toxemia in tuberculous patients and that this indicates diminishing absorption of toxic products from the lesion; diminishing absorption means less elaboration of toxic products in the lesion and less diffusion through tissue and vascular fluids; this in turn reflects subsidence of inflammation and necrosis. Finally, all this permits reparative forces to come into play, producing fibrosis of the lesions and the damaged tissue. It seems to me too limited a view to assume that rest produces benefit merely by diminishing the mobility of the lungs on account of smaller respiratory demands. Mechanically this should reduce the exudation and diffusion of toxic products locally, but another and possibly more important effect of rest is the relatively great diminution of circulating fluids through the p monary blood vessels and lymphatics, a mechan which militates against the exchange of fluids only through the capillaries, but also through lesion and the surrounding tissues. The importa of physiological tone upon local mechanisms hardly be more than inferred. The varying per ability of capillaries must have a good deal to with the diffusion of toxic products in and about lesion. If, as seems reasonable, the promotion physiological processes through rest and the avo ance of fatigue favors better tone and lesser capillary permeability, we have a logical basis for institution of rest while the tuberculous inflamm tion is still susceptible of resolution. It will be int esting also to watch future investigations to lea better how mental composure and emotional sereni operate to promote physiological tone and heali of inflammatory lesions.

Stated specifically, the purpose of treatment early pulmonary tuberculosis, aside from restori physiological health, is primarily to promote resol tion of inflammation, to arrest necrosis and gua against transbronchial dissemination; and then maintain a condition of inactivity and latency un adequate fibrosis has had time to develop. Resolutic may be relatively rapid and may be observed roentgenograms during a period of a few we after treatment has been instituted. Fibrosis may th start and progressively increase, but the rate development is very slow. If resolution has remove inflammatory products before much caseous necros has occurred, the final result is likely to be a rel tively clean and durable scar. If, however, fibros encloses and encapsulates considerable caseo residues, more time is required to assure the durabi ity of healing and to guard against later exacerb tions.

As an average the period of rest in bed for th young person with an early pulmonary infiltrat varies from three months to a year. This is a individual matter and must be judged according t the progress of the case as confirmed by repetition of all diagnostic tests. Resolution demonstrated b x-ray, the disappearance of tubercle bacilli fron the bronchial discharges, and the maintenance o return of good general health which go with latency and beginning fibrosis are deceptive to the patien and sometimes also to the physician. While slowly graduated activity usually may be resumed within six months to a year after treatment has been started medical supervision and regulation of the patient's

daily life is indicated for the next year or two. Avoidance of excesses is then the best guarantee that the healing will be permanent.

That prolonged confinement, particularly rest in bed, has certain disadvantages is evident to all. In elderly tuberculous people in whom the disease is usually chronic and the effects of rest are not as striking as in the young, compromises may be necessary and reasonable, but, since the disease puts in its appearance most often in adolescence and early adult life, and since the effects of confinement are not so objectionable physiologically in young people, and since the stakes in health and life are so great, disadvantages are mitigated by the assumption that the price of recovery is small compared with the possible alternatives, chronic illness and shortened life. How fully the patient may be convinced of this depends greatly on the knowledge, conviction and interest of the physician. It is not usually difficult to secure the acquiescence and cooperation of intelligent young people. It is most unusual to encounter a well educated and trained young medical intern or nurse who will not accept necessary treatment with the right philosophy.

I have said nothing concerning artificial pneumothorax or other forms of collapse therapy in the treatment of early tuberculosis. As a general principle, collapse therapy is ideally suited for the case in which active inflammation has abated, leaving a cavitary defect which does not heal because of mechanical hindrances and which constitutes a permanent menace. However, before active inflammation has subsided and caseous necrotic lesions have been sloughed out, good effects of collapse alone are much less apparent. In the pneumonic case treated by pneumothorax, for instance, it is observed that the incidence of tuberculous pleural effusion and empyema is high. Since tuberculosis is not likely to heal adequately until all the native defenses of the body become mobilized against it, no treatment can be expected to suffice for the early inflammatory lesion unless at the start this includes rest and, usually, rest in bed.

This discussion has touched upon many phases of tuberculosis in an attempt to arouse your thinking on fundamental pathogenetic and clinical principles. There is a reason for this in the observation that the disease is so often considered and treated as if it were a simple infection or a simple mechanical process, with little regard for the fundamentals. Without some such orientation the clinician is at a serious disadvantage and may make fatal mistakes. Once the intrinsic mechanisms and potentialities of tuberculosis are recognized and appreciated, proper management and treatment usually become fairly obvious. Intelligent execution of the treatment then results in permanent recovery in nine cases out of ten. Could such conceptions be followed generally, advanced tuberculosis would soon become uncommon and the case fatality would approach the vanishing point. Transmission of infection to healthy people would be minimized, and this, after all, is the chief hope of eliminating this serious menace to the public health.

# MEETING COMMUNITY RESPONSIBILITY FOR THE CONTROL OF TUBERCULOSIS

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RATHER than talk on the title of "Meeting Community Responsibility for the Control of Tuberculosis," I would prefer to change this to a question, namely, "Are we meeting our community responsibilities for the control of tuberculosis?"

In answer to this question, there are some indications that we are meeting our responsibilities, and some that we are not. Dr. Locke has very ably told of the early trials and developments of the program for tuberculosis control in this city. The fact that there has been such a growth and such change should give us all assurance that in some measure, at least, we are meeting these responsibilities. We may also gain satisfaction from the fact that in the past twenty years in Hartford there has been a reduction of some 54 per cent in the mortality rate from this disease. There is also some satisfaction to us in the fact that the mortality rate from tuberculosis in this city is less than that for the United States as a whole.

On the other side of the ledger are some indications, however, that we are not completely meeting this responsibility. Our death rate in Hartford is higher than is the death rate in the state of Connecticut as a whole. Can we sit back complacently and say that that situation must remain, that we and that Hartford cannot achieve the same measure of health as can be achieved in the State of Connecticut? We should also be somewhat dissatisfied with the fact that in the past ten years the reduction in mortality has not been as great as in the ten years preceding.

There are indications today in many parts of the country of a possible increase in the mortality from tuberculosis—an increase which need not occur if all of the people of this community apply the knowledge that we have today for the control of this disease. There is also some indication that we hav not met completely our responsibility for contro of tuberculosis, because in the past year there wer in this city 72 deaths from a preventable disease. In asmuch as tuberculosis is a preventable disease, w cannot say that we have met our full responsibilit until tuberculosis has been eradicated.

Responsibilities for the control of tuberculosi cannot be discharged by any one organization in a community. The effects of this disease reach out into all parts of the community and affect the well being of all types of people. In somewhat similar manne the work of all types of people and organization can affect the program of tuberculosis control.

Tonight we are concerned particularly with the role of the tuberculosis society in this community-wide campaign. In picturing our role, however, we must bear certain things in mind. First is that the health officer of any community is legally responsible for the control of communicable disease; and as such, is responsible for the control of tuberculosis. We cannot and should not remove from him that responsibility. One of our important functions is to support and aid him in doing a better job.

We must also remember that by common acceptance, the practicing physician is responsible for maintaining the health of the families under his care. That responsibility, too, we cannot attempt to assume, but must play our role in helping the family physician to meet this obligation which he is attempting to meet every day. We must also remember that schools and welfare organizations of one sort or another have activities and interests that touch the problem of tuberculosis control in one respect or another, and we must give due consideration to the special skills and functions of these other organizations.

In other words, we need a joint community undertaking if our program for tuberculosis control is to be adequate. Briefly, the program for tuberculosis is

*The abstract of a paper delivered before the Hartford Tuberculosis and Public Health Society January 30, 1945*

imple when reduced to its fundamentals. It is based n a program of finding the case, isolating and treating the case, and of education.

In finding the case, we have the accepted facilities f clinics for those who have been in contact with he disease and who have suspicious symptoms; and n the manifold activities of the practicing physiians, who have it in their power to conduct the nost effective case finding program in the commuity. We also have the rather new development of ertain mass case finding techniques, through x-ray nd the like. The aim in any community should be o have the greatest possible number of people, deally the entire population, secure an adequate examination by x-ray. We must examine this whole problem to determine what obstacles and hurdles here are in securing for all the people adequate examinations.

As for treatment, it has been long agreed that the providing of facilities for care of this disease is a public responsibility and must be met by tax funds. However, that does not relieve the voluntary association of a responsibility to see that in any given community there exist adequate facilities for treatment of tuberculosis, and furthermore, if these adequate facilities exist, that they are utilized to the fullest possible extent.

Included in the role of treatment is the large problem of rehabilitation. Certainly it would be a travesty to consider treatment concluded before the patient has been restored to his normal place in the community in which he lives. Activity in rehabilitation is relatively new, and here is a great field for exploration and experimentation, in which the tuberculosis association can and should play a leading role.

Education should be an active, living force, directed to meet the changing needs in any local community from day to day. Education should include community activities and efforts to secure facilities, and once the facilities are secured, to see that they are used by all.

From what I have said, you can readily see that there is no ideal program for any one tuberculosis association. The program should change from year to year to meet the changing needs. In order to do this, I would strongly recommend that an association establish a strong community-wide committee to consider the problems of tuberculosis control. This committee should include representatives of private medicine, the health department, and various civic groups. This committee should at the start lock the checkbook in the safe, so thinking will not be influenced by financial considerations. This committee should attempt to determine the problems to be met in the community to secure adequate control of tuberculosis. It should, if possible, place these problems in the order of importance and for each one enumerate the specific projects which could be undertaken to meet it.

Once having determined the problems and the projects needed to solve them, consideration can then be given to the financial means of meeting them. In meeting them, there can be no room for rivalry or competition. The agency, individual or group best equipped to meet those needs should be assigned that responsibility. We are all working for the common objective: the eradication of tuberculosis. We are not after credit or recognition. We are after results. By pooling our planning a clearer picture can be obtained and from it more effective results.

The question has also been raised of other health problems in the community. The tuberculosis association has been dedicated to the control of tuberculosis. We must not dissipate our energies in other directions, but neither can we close our eyes to other problems of health in our community. In addition to a responsibility for tuberculosis control, we also have a responsibility for sound community planning in meeting all our health problems.

In summary, our adequate program for tuberculosis control can come only through constant, effective study of the facts regarding the situation in our community. From thost facts we should determine our specific objectives and activities; and those activities should in turn be delegated to the organization best equipped to carry them out. The problem of tuberculosis control is one that can be solved. It can be solved only by the people in a community when those people are determined to solve it.

# THE DOCTOR AND GROUP INSURANCE

HARLAN S. DON CARLOS, *Hartford*

The Author. *Manager, Life, Accident and Group Claim Department, The Travelers Insurance Company*

THE International Claim Association* is happy to have this opportunity to present the problems and objectives of voluntary group insurance claim administration. It is our intention to speak frankly and without reservation. Not only is such an approach necessary to complete understanding, but thoroughly agreeable to us and, we hope, to you. Perhaps, if there had been the opportunity to submit this paper to each and every one of the more than two hundred member companies of the Association before reading it here, some slight differences of opinion on its content and styling would have developed. As it is, this commentator must be said to be expressing his own views. However, it is safe to say there is little difference in the viewpoints of those of us engaged in group insurance claim work.

Frankly, our purpose here is to ask all the doctors in this nation to cooperate with us and to participate in the successful administration of voluntary group insurance plans. We have no hesitancy in such a proposal. On the contrary, we believe we should have come to the medical profession with it long before this. It is a matter of mutual interest and concern. Plans evolved for the hospitalization and surgical care of the population of the United States, and indemnifying workers for time lost through illness and injury, will be influenced by the success or failure of the medical profession, industry, workers and the insurance companies, to administer voluntary group insurance plans so well that the maximun benefits may be given for a low cost.

Your objectives and ours in this program are iden tical. We both want the prompt payment in full o every meritorious claim. We both want the elimina tion of any abuses of the plan by claimants Especially at this time, we do not want absenteeisn encouraged or lengthened by the payment of un deserved insurance benefits. Upon these bases, we both want the extension of group insurance protec tion to more and more workers and their depend ents, and suiting the coverage and benefits to thei needs at the lowest possible cost to them. We both want the worker's insurance to provide him with funds for the prompt payment of the well earned fees of his doctor and the costs of hospital care which even now are being paid out by the insurance companies in many millions of dollars each year. We both want to maintain good will and teamwork of partnership and understanding between the medical profession, industrial management, the workers, and the insurance companies.

What we both may or may not want in what some allege to be the politics of the various proposals, I deliberately omit in the interest of a factual, informative and non controversial presentation of our other problems. However, having raised that point at all, it is only fair to say, first, we do not offer voluntary group insurance as a complete answer to the demands for medical services to every individual in the land. Secondly, we do not ask you to help us sell group insurance—the sole task confronting the group claim executives and, I submit, an important task confronting you of the medical profession, is successful group claims administration. Third, you and we must give our wholehearted support to the successful administration of whatever plan, or plans, may be provided at any given time in any place for medical services—in other words, the best public interest should be our highest aim and constant guide at all times. Fourth, if you and we

*The International Claim Association, organized in 1909 by the claim executives in insurance companies, has as its constant aim the improvement of claim service to the insuring public. For many years it has cooperated with the American Medical Association, hospital and other associations, in the simplification of blanks and procedures in the medical phases of claims.

*This paper was prepared for the meeting of the National Conference on Medical Care, scheduled for February 11, 1945 in Chicago, which was cancelled*

do a good job and give the public what it wants and needs within the limits to which voluntary group insurance can be expanded, I for one have no fear of the ultimate political outcome.

The community of your interest and ours, in successful group claim administration, is not impaired by our profit motive. The basic formula of profit to the company is a small margin, representing in the long run a percentage of the premium necessary to pay claims and administrative expenses. Therefore, in fact, the dollars and cents profit decreases with the decrease in claims. To put it bluntly, we are not asking you to help us make more money when we ask your participation in making a success of group claim administration.

This audience need only be reminded of the following few incontrovertible truths to get in mental step with us as we take you behind the scenes and through some of our more intriguing fields of group claim problems. We ask along the way for the benefit of your experience and wise counsel in their solution.

*First*, the attending physician is the key man in practically every group claim.

*Second*, the insurance benefits which can be provided by a premium dollar are dictated by claim payment experience.

*Third*, in line with an increasing claim cost of insurance coverage, the premium, theoretically at least, can be increased indefinitely—but, not far along that road, the whole plan will fall of its own weight. Then what?

It is quite apparent that, while it is the responsibility of the underwriters and actuaries to devise and provide the best possible coverage to suit the needs of the worker and his dependents, and though the claim man must give the best possible claim service, the claim cost is far more within the control of the attending physician and the worker himself.

Let us examine for a few moments the types of benefits available under voluntary group insurance policies issued by insurance companies. This seems necessary in view of the indefinite and repeated reference to "medical care" plans which it is said are offered by the companies.

First and oldest of the lines is group life insurance, payable upon death from any cause. The beneficiary may be named and changed from time to time by the insured employee. It may be paid in a lump sum or interest bearing instalments.

Second, there is the accident death coverage, also covering accidental dismemberment and loss of sight. It may cover any such loss or only those which are non occupational in origin.

Third, is the weekly indemnity coverage for loss of working time due to non occupational accidental injury or illness. Generally, the first few days of disability are not covered. The standard plan does not pay where the same loss is paid under workmen's compensation or similar law. The claims require the certification of the attending physician.

Fourth, is the hospital and surgical coverage which pays a stated amount per day during hospital confinement up to a certain number of days, reimbursement for special hospital charges, such as x-rays, laboratory, use of operating room and anesthetic, up to a specified amount, which is usually five times the daily hospital indemnity rate and, in addition, reimbursement for the surgeon's fee for surgical procedures up to maximum amounts stated in the schedule printed in the policy. This coverage, with minor modifications, is available to the worker's dependents, for an additional premium.

Fifth, there has been issued a coverage for doctor's treatments in the hospital, his office or the patient's home, usually eliminating the first three treatments. A stated amount, say, $2 each for hospital and office calls, and $3 each for home calls, is paid up to $75, or some other stated limit, for any one condition.

This latter coverage—reimbursement for doctor's calls—is what some uninformed seem to think is meant by "medical care." Yet, so far, there is little of it in force under insurance company plans in proportion to the whole group insurance program. Just how much need there is for it on the part of workers who can pay for it in normal times, is in considerable doubt. Our limited experience with it makes one thing certain—the uncertainty of its claim cost at the time the risk is undertaken. Suppose we start our tour behind the claim scenes with the problems arising in this coverage and then get back to the more standard lines.

Attending physicians tell us that, after the first three calls, for which the patient pays without reimbursement, there is a decided tendency on the part of many to continue calling at the doctor's office, or even calling the doctor to the patient's home, long after there is any necessity for treatment. This spells unanticipated additional claim dollar cost.

Then, here's a problem with controversial possibilities. Before the coverage was effective, John Smith had a cold. His doctor medicated his nose and throat, gave him some pills and told him to go home and stay in bed a day or two, and drink a lot of water. It all worked out fine. John went back to work. Both he and the doctor forgot all about it. But, now, John has bought this new coverage. He has a cold. What happens? The same thing, except the doctor now tells John that just as soon as his cold symptoms subside, he should take a series of cold shots. John gets them free. The doctor says it is good medical practice, now made possible by this insurance cover. So, many common colds which were not supposed to participate in the distribution of these funds to any great extent, cost more claim dollars than anticipated. Similar situations develop in the treatment of other conditions—directly attributable to the insurance reimbursement for treatments. Please understand there is no thought of criticism involved in our presenting this illustration. Preventive treatment is exclusively within the medical province. It is just another factor to correct the thought of those who assume that the cost of the doctors' calls and treatments would be the same if covered by any plan as the cost is now, without such coverage. Also, it is yet to be decided whether it is an essential part of the medical, surgical, hospital and indemnity coverage plans so widely discussed. It may well be that the average American worker is not interested in coverage for ordinary medical expense. Recent polls of workmen's opinion so indicate.

It is to be noted, however, that these comments leave open for discussion and possible development some coverage to be designed for the catastrophic expense involved in the treatment of some conditions over a long period of time, without hospitalization or surgical procedures.

The hospital and surgical covers are much easier to handle in claims. The increasing cost is due chiefly to two factors. When it is first placed, those who have been postponing minor surgical procedures, sometimes major ones, sign up immediately and then have those operations. In general, a more favorable claim experience may be anticipated if practically 100 per cent of the group take the coverage.

Second, there is a marked tendency for the doctors and the hospitals to use hospital facilities in minor surgical cases where this type of coverage is in effect, and for longer periods than was the case before the coverage became so widespread, if the hospital is not too crowded or short-handed. Especially do we find this so where, as in some policies the surgeon's fee is payable only for those procedures done in the hospital.

At this point in our discussion let us consider the present necessity for limitations in coverage. An insurance company can cover almost any contingency which can be anticipated in advance—for a premium which will cover the claim payments, the cost of administering the cover and a small margin of profit. It is really no more than a conduit into which flow the stipulated contributions of the worker and of the employer, and out of which flow the benefits to those who need them. The coverages should be fitted as nearly as possible to the needs of the worker. Competing companies estimate the premium necessary and submit their proposals. The loss experience of the group thereafter determines whether the premium was too high. If so, an adjustment is made. If the losses exceed the premium, the employees and the employer must chip in more money to continue the coverage. If the additional premium necessary for renewal of the policy becomes too great, it can and probably will be dropped and the workers left without the protection. All workers, doctors and hospitals who realize how much benefit the coverage is to them and to each other must share the responsibility for its continuance and enlargement.

The amounts up to which reimbursement of surgeons' fees will be paid for surgical procedures are covered for the most part in the printed schedule in the policy. For those not appearing in the schedule, a proportionate amount is set by the company in each instance. The maximum for all procedures in one claim is usually $150. The amounts stated in the schedule and the amounts allowed for procedures not in the schedule are in no sense an estimate of what the surgeon should charge or an evaluation of his services.

The weekly indemnity for total disability due to injury or illness presents more complicated problems and requires the greatest degree of cooperation by all concerned. We need not dwell upon its obvious economic, healthful, morale sustaining benefit, when properly administered.

The outstanding factor in rapidly increasing loss ratios in this line is one which could hardly have been anticipated by the actuaries and underwriters in normal times, or prior to the claim experience we have now had, and are still having, in wartime, with a greatly increased percentage of married women

workers in the insured groups. Their claim loss ratio is considerably higher than that of male employees and single females, in the weekly indemnity coverage. This is not a general finding of lack of integrity among married women. The over-all picture is that of trying to do too much by working in a plant and taking care of a home and family in the non working hours the average male employee devotes to rest and recreation.

Among the male employees we have a somewhat similar problem, so far as the unmeritorious claim is concerned. These days of high wages and pressure for manpower bring to the plants many workers from considerable distances, over which they commute every day or sometimes less frequently. It is interesting to note that as high as 70 per cent of commuters' claims end on Mondays. Also, among workers from farms there is a marked rise of claim frequency during the planting and harvesting seasons.

The above problems in weekly indemnity claims are somewhat peculiar to war conditions, which we all hope will disappear soon. Although such unwarranted claims are doing considerable harm to the success and proper growth of voluntary group insurance, their most urgent message to you and to us is that such claims be carefully scrutinized by the attending physician and by us, and that his claim certification and our claim payment be limited to total disability due solely to injury or illness—in order that we do not encourage and contribute to the frequency and increased periods of absenteeism.

Now, let us consider a few problems which will always be found in weekly indemnity plans—although they, too, are accentuated in wartime and also contribute to absenteeism.

In several plants today there is a company or employee benefit plan paying the disabled worker a weekly benefit in addition to the insurance company group plan. Sometimes the two benefits total more than the claimant's earnings, if he has been in the employ of that concern long enough. Remember, disability indemnity payments are tax free. One large concern is now planning a wage adjustment plan for the disabled worker, deliberately designed to give him more income while disabled than when he is at work—to cover his normal living expenses plus the costs of doctors, medicines, etc. While you and we do not want to discourage a liberal and considerate policy toward the workers, we know from experience that when you put a premium on disability, you get enough added disability to endanger any group insurance plan. Something less than full coverage is necessary to prevent gradually increasing abuse.

Let us look at a few of the findings established by the statistical studies of Mr. Andrew Court of the Labor Economics Section of the General Motors Corporation:

". . . when time lost for sickness is compensated in full, compared with no indemnity . . . fully paid men had three or four times as many short term sicknesses and about the same number of longer duration."

". . . although serious sickness is much more of a problem among older persons, short term absenteeism is concentrated in the younger age groups."

". . . many short term disabilities as ordinarily reported among industrial workers result from a very particular kind of sickness that afflicts younger persons on the day after payday or just before or after a holiday, or at the opening of a hunting season."

In order that you may know our comments indicating abuse of the weekly indemnity are not just impressions or theoretical, one company recently investigated 140 run-of-the-mill pending group weekly indemnity claims in one war plant. Forty of the claims were closed immediately upon the findings. Thirty-four other claimants were not at home, or in the hospital, when the investigator called. Sixty-six (less than half of the total) were found to be genuinely disabled.

It is interesting to note at this point some figures released by the Rhode Island state-administered sick benefit plan. Out of 6,000 claimants ordered to appear for examinations before board physicians in support of their claims for sickness benefits, more than 1,400 (or nearly one-quarter) failed to put in an appearance at all and thus automatically put an end to their claims. Of the remainder, about 1,650 persons were denied benefits after examination by board physicians, slightly more than 2,700 had their claims approved, and 205 others were requested to submit to laboratory tests.

These highlights of the coverage and some of the problems involved in the claim administration of them have been offered as a basis of more complete understanding of what it is you and we are trying to do, and how we may improve the performance of our respective responsibilities in the program.

The part to be played by the claim man often is misunderstood. Occasionally, you will hear from misinformed sources that the claim man's job is to save as much money as possible in claims. Nothing could be further from the truth. It is his duty to discharge the obligations of his company in claims as promptly and as courteously as possible, paying every cent due in every claim. But, at the same time, it is necessary for him to conserve the workers' funds for those who are rightfully entitled to them. The claim man is primarily a service man and upon his performance depends the good will and growth of his company.

In presenting the problems of claim administration, we do not mean to give you the impression that every claimant is a malingerer and lacking in integrity. On the contrary, the vast majority of workers are entirely honest and the well informed ones resent more than you or we do the unfair claim by a fellow worker. It is no exaggeration to say that the workers themselves look to you and to us to preserve the group plan for their protection and to curb the abuses which endanger its continuation.

There has been plenty of evidence that enlightened industrial management is ready to cooperate fully with us at all times in the furtherance of the group plan.

We have already indicated that in our opinion voluntary group insurance is not the whole answer to the current discussion of medical care. No matter how perfect our administration of the plan becomes, it will have to be supplemented by such plans as the Blue Cross and other hospital plans, by medical care plans sponsored by medical associations or other groups of doctors, by continually improved workmen's compensation laws and by the necessarily tax supported local, state and government plans for the care of the indigent, and by the continuation and improvement of the preventive work in tuberculosis and other fields. And, of course, there are millions of individual policies in force covering accident, sickness, hospital and surgical care. We think it important that such a perspective be constantly in mind and we suggest that proponents of the various other plans often lose this perspective in urging some one plan as the cure-all. Such over estimates only serve to give the public a confused, kaleidoscopic set of impressions which make it difficult to gain public support for a properly balanced set of plans supplementing each other in solution of this complicated problem in its entirety. Nothing would give me greater pleasure at this point than to yield to speakers who could describe adequately the splendid contributions each of the plans has made—as proof that no one of them should be discarded. In such a discourse there would also be developed the fine work and rapid progress in the fields of industrial medicine and safety engineering, which undoubtedly will play an important part in achieving the country's goal of better health and fewer injuries.

In conclusion, we are convinced that the medical profession and the group insurance claim men should, as soon as practical, combine their experience, ability and efforts to solve the problems and to achieve the goals we have tried to point out to you in this discussion. We submit that the first step in this procedure is to acquaint the doctors of the country with these problems and our mutual goal. This, in turn, we are told, can best be done through the County Medical Societies, with each State Medical Association guiding the program to the County organizations. If you feel that this discussion gives an insight into the problems of group claim administration and will be helpful to the medical profession, the International Claim Association will endeavor to provide speakers in response to invitations from the County or other local Medical Socieites, or Associations. It is possible that in some localities where one large industry employs a large percentage of the workers, it will sponsor and conduct such a meeting—as has already been done by the Hercules Powder Company in Roanoke, Virginia, last September.

Only with your understanding and participation can we best serve the public interest to which you and we are pledged.

# THE VALUE OF CARDIOGRAMS

## As an Aid to Early Diagnosis in Suspected Cardiovascular Emergencies

C. F. Yeager, M.D., *Remington Arms Company, Inc., Bridgeport*

Since no one can predict the time or place at which heart attacks will occur, it is obvious that in only a small percentage of cases is it practically possible to make electrocardiographic tracings within a few moments of the emergency. In the majority of cases, the first electrocardiogram may be made several days or even weeks after the attack. Consequently, there is, at the present time, in spite of much study of the subject, some doubt as to the diagnostic value of cardiograms taken during the acute stages of coronary occlusion.

This situation need not hold when the potential patient is as closely associated with hospital facilities as he is in an industrial plant with proper medical supervision. Today a number of industries make use of electrocardiographic equipment routinely in preplacement examinations and periodic physical examinations, especially on employees over 45 years of age. In addition, cardiograms may be taken on all employees showing any evidence of heart disease regardless of age, and, finally on all employees who request emergency treatment or advice at the plant dispensary with symptoms resembling acute heart conditions.

Although a great deal can be said about the value of cardiograms in all three of these situations, the most valuable information has resulted from a study of the third group of cases. This report will, therefore, be limited to a group of 31 employees who reported during a five-year period to the plant dispensary of one industry, presenting symptoms resembling acute coronary occlusion. In all these cases tracings were taken and interpreted within 15 minutes following the onset of the attack.

Naturally, the symptoms of this group were variable and some were definitely atypical. Three of the coronaries had no precordial distress, and only three of them were brought to the plant dispensary on stretchers; the remainder either walked to the dispensary alone or with assistance. They were all put to bed on arrival in the dispensary ward, and the electrodes applied immediately. The treatment was entirely symptomatic and included one or more of the following: morphine, aminophyllin, coramine, adrenalin, caffeine sodium benzoate, digalin, amyl nitrite, nitroglycerine, and oxygen. In some cases tracings were taken prior to medication; most of them, however, were taken within a very few minutes afterwards.

Although space does not permit publication of tracings and reports on all cases, the following have been selected to demonstrate the representative results:

Case No. 1: Male; age 42; weight 159; height 5 ft. 5 in.; employed as office worker. Previous history and annual physical examinations since 1934 negative except for a gradual elevation of blood pressure from 135/84 to 150/88. No previous cardiograms were taken.

This employee walked (escorted) to the plant dispensary, complaining of intense pain in his upper anterior chest. He was put to bed immediately in the ward and the electrodes were applied within a few minutes. Morphine sulphate. gr. ¼, was given hypodermically about 10 minutes after admission. He stated that he shoveled snow before coming to work and walked briskly to place of employment in a snowstorm. He felt slight precordial distress just before arriving at the plant, and after reaching the office the pain became much worse. He was ashen gray; perspiration on his forehead; skin cold and clammy; pulse 100; respirations 20; blood pressure 160/94; temperature 98; heart sounds were forceful—accentuated $A_2$; no murmurs were heard.

First Cardiogram (A) taken at 9:30 A. M.—graphic interpretation:—lead 3 shows a marked prolongation of the R-T Segment and a biphasic T wave; there is a small $Q_4$ and a biphasic $T_4$.

Cardiogram B taken at 12:30 P. M. the same day—patient still in bed; shows a lowering of the R-T segment in lead 3 and a high R-$T_4$.

Cardiogram C taken at 3:00 P. M. the same day—shows normal complex in lead 3 but a persistent high R-$T_4$.

*Reprinted from Industrial Medicine, August 1944, with permission of the publisher*

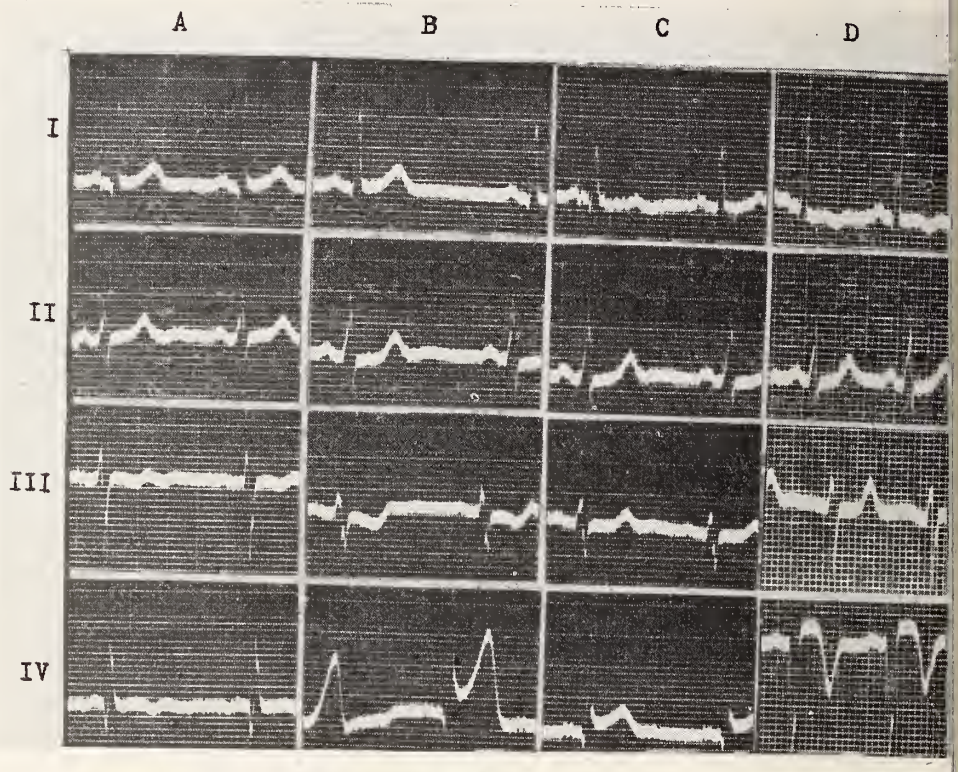
Employee was transferred by ambulance to a local hospital where he remained at complete bed rest for 47 days.

Cardiogram D taken upon discharge from hospital shows a coved T in lead 1 and a deep coved T in lead 4.

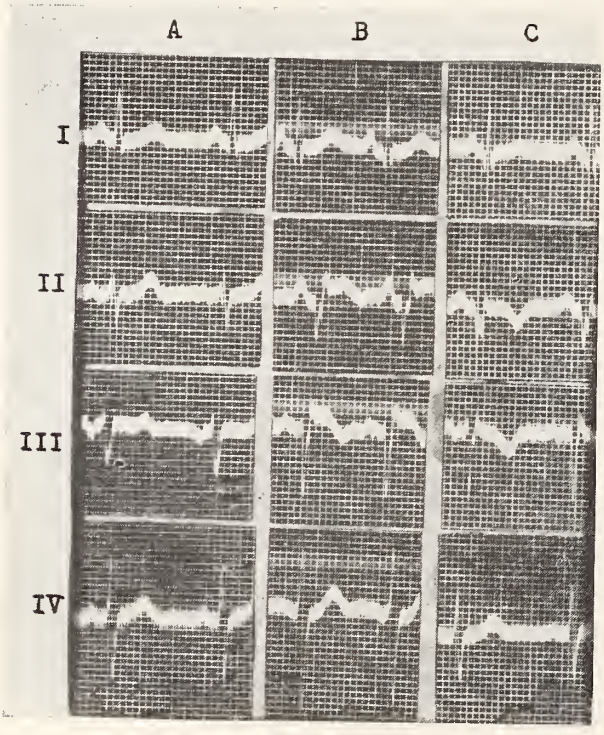
Graphic and Clinical Conclusions: The first three tracing are those seen with myocardial ischemia and may be due t coronary sclerosis or coronary occlusion. The last cardio gram shows the type of tracing seen with an old or heale anterior wall infarction.

| | |
|---|---|
| Total cardiographed cases with suspected coronary occlusions | 31 |
| *Total cases showing evidence of acute coronary occlusions | 16 |
| Total cases showing ECG evidence of other cardiac conditions | 6 |
| Total cases showing no ECG evidence of cardiovascular disease | 9 |
| Final Diagnosis: | |
| 1. Coronary occlusions | 16 |
| 2. Anginal seizures | 2 |
| 3. Coronary sclerosis | 2 |
| 4. Auricular fibrillation | 1 |
| 5. Supra ventricular tachycardia | 1 |
| 6. Conditions other than cardiovascular | 7 |
| 7. Undiagnosed | 2 |
| Total | 31 |

*Eleven of the 16 had cardiograms interpreted as negative on previous physicial examinations.




Case No. 1




Case No. 2

Case No. 2: Male; age 60; weight 182; height 5 ft. 8 in.; previous annual physical examinations since 1934 entirely negative; previous cardiograms negative; occupation, draftsman.

He walked unescorted to the plant dispensary immediately after lunch, complaining of pain in the left side of neck, left jaw, left arm, and at the lower tip of the left scapula. Pulse 110; blood pressure 150/90; temperature 98.6; respirations 16; skin was clear, good color, ruddy complexion. Patient was put to bed and electrodes applied immediately.

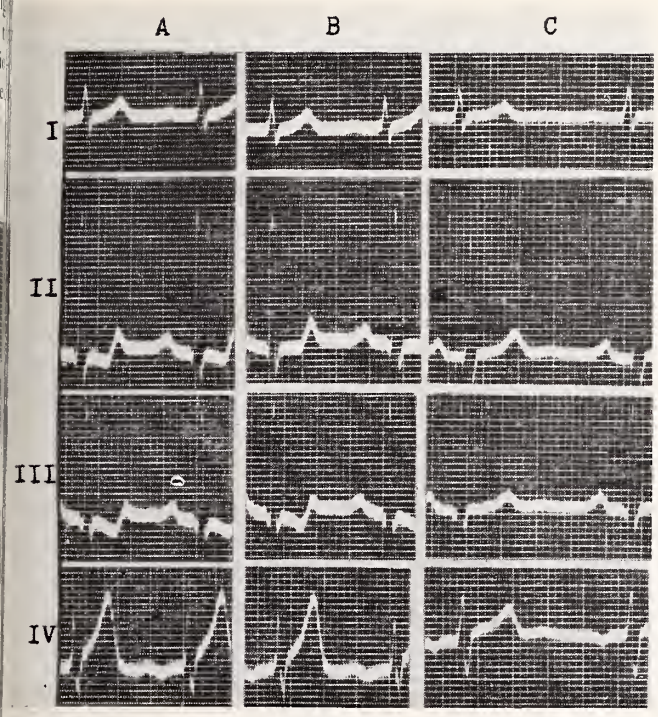
Cardiogram A was taken a year prior to his attack and may be interpreted as negative.

Cardiogram B, taken on admission to the plant dispensary with the above complaints, shows a high R-T segment in leads 2 and 3 and a $Q_2$.

Employee refused hospitalization and was taken home by car. Two days later he was admitted to a hospital because of persistent precordial pain.

Cardiogram C was taken 35 days later, during which time he was at complete bed rest, and shows $Q_2$ and negative $T_2$ and $T_3$.

Graphically and clinically this employee had a posterior wall infarction.




Case No. 3

Case No. 3: Male; age 57; occupation, machinist; weight 27; height 5 ft. 7 in.; previous physical examinations over a three-year period showed mild hypertension averaging 145/85 and a mitral systolic murmur at the apex.

This employee was seized with sudden severe pain in the heart upon his return from lunch. He collapsed from weakness and pain with no loss of consciousness and was brought to the plant dispensary on a stretcher. He was put to bed immediately and electrodes applied. Pulse 110, feeble; temperature 98; blood pressure 148/78; heart sounds were poor and distant. One ampule of amyl nitrite gave only slight relief; morphine sulphate, gr. ¼, was given later hypodermically.

Cardiogram A, taken within a few minutes after arrival at the dispensary, shows a lowering of the R-T segments in leads 2 and 3 and large T waves in lead 4.

Cardiogram B, taken 15 minutes later, show practically normal complexes in lead 2.

The employee was taken home and advised complete bed rest for two weeks.

Cardiogram C, taken five days later, may be interpreted as perfectly normal. Physical examination made at this time was also negative. Patient was advised continued bed rest for another week or 10 days.

The next day, however, the employee died very suddenly during an attack of severe precordial pain.

Graphic and Clinical Conclusions: On the basis of the negative third cardiogram the first two were interpreted as an anginal seizure, which is frequently the forerunner of a true coronary occlusion.

### CONCLUSIONS

Cardiographic evidence of coronary occlusions and angina was obtained during the attack in 18 of the cases studied. From the results we are convinced that many lives can be saved or prolonged by taking electrocardiographic tracings immediately on individuals presenting atypical or questionable symptoms of acute coronary disease. We believe that organizations having cardiograph equipment will find it very useful as an aid to earlier and possibly immediate diagnosis in certain suspected cardiac emergencies.

# CHOLINE AND INOSITOL THERAPY OF CIRRHOSIS OF THE LIVER

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THE RELATIONSHIP between the ingestion of alcohol and the occurrence of cirrhosis of the liver has long been recognized, but the pathogenesis of the peculiar changes occurring in Laennec's cirrhosis has remained obscure. In recent years newer techniques and knowledge have been applied to the study of this disease, and slowly the dim outlines of the picture are becoming sharper and more definitive. These studies have emphasized the lipotropic activity of both choline and inositol, and suggest their use in the therapy of cirrhosis of the liver in man. Four such case histories are herewith presented.

*From the Laboratory, Medical and Gynecological Divisions of the New Britain General Hospital, New Britain, Conn., and the Department of Pathology, Yale University School of Medicine, New Haven, Conn.*

*We are indebted to Dr. T. H. Jukes of Lederle Laboratories, Pearl River, New York, for a generous supply of choline and inositol. The choline was prepared as choline dihydrogen citrate syrup, and the inositol in 500 mg. tablets*

REVIEW OF LITERATURE

Curtis[1] and his co-workers demonstrated that the addition of a small amount of cystine to an 8 per cent casein diet produced slowly progressive interlobular necrosis in the liver of rats. Later Earle and Victor[2] demonstrated that cystine fed to albino rats as 10 per cent of the diet produced portal hemorrhagic necrosis resembling eclampsia in three to four days, fatty infiltration in all rats surviving the initial acute lesion, and cirrhosis of the liver in rats surviving more than two weeks. Rich and Hamilton[3] observed cirrhosis of the liver, of a type resembling Laennec's cirrhosis in man, in all of 14 rabbits kept from 25 to 113 days on diets supplemented by various vitamins but lacking yeast. Connor and Chaikoff[4] fed dogs a high fat diet supplemented by alcohol. All of 16 animals so treated developed fatty livers, and 4 showed definite cirrhosis similar to that observed in early fatty cirrhosis in man. Later these same authors[5] followed dogs fed a high fat diet consisting of lard and lean meat, and without alcohol supplements. Three of four animals showed a severe diffuse fibrosis, and all developed hepatic fatty infiltration. Other investigators have reported the production of hepatic changes by various dietary means. Thus Blumberg and McCollum[6] observed cirrhosis of the liver in more than 30 rats fed a high fat, low protein diet, and György and Goldblatt[7] reported liver necrosis or cirrhosis or both in rats on a diet of 10 per cent casein and 22 per cent fat. These investigators also noted[8] parenchymatous degeneration, fatty changes, focal and massive necrosis, hyperemia, hemorrhage and occasionally perilobular and condensation fibrosis in rats fed a basal diet deficient in vitamin B complex and supplemented by vitamin $B_1$ and riboflavin, or vitamins $B_1$ and $B_6$ and riboflavin. These hepatic changes were regularly prevented by the addition of yeast or yeast extract, suggesting that they were related to a deficiency of a part of the vitamin $B_2$ complex. The relationship of alcohol as a possible factor in the production of cirrhosis is suggested by the observations of Lillie and his co-workers[9] who noted the production of hepatic cirrhosis in rats fed a low protein, low sulfur-containing amino acids diet. The changes appeared more severe when alcohol was substituted for drinking water. Daft and his associates[10] demonstrated the consistent production of liver cirrhosis in rats on a low protein, low fat diet with added cystine. These changes were studied histologically by Lillie[11] who noted a peculiar type of fatty cirrhosis, characterized by fatty infiltration and by a hyaline substance terme "ceroid." In summary, various types of liver change ranging from fatty infiltration, to necrosis, to fibros resembling cirrhosis of the liver in man, have bee produced in rats, rabbits and dogs, on high fat diet with or without alcohol supplements, on yeas deficient and vitamin $B_2$ deficient diets, on diet containing cystine or casein and fat, and on low pro tein low fat diets with added cystine.

In 1932 Best, Hershey and Huntsman[12] reporte that the deposition of fat in the livers of norma white rats, produced by a high fat diet, could b prevented or reduced by the administration o lecithin. Equivalent amounts of choline which migh be derived from the effective dose of lecithin had similar inhibitory effect. Later MacLean and Best[1 noted that choline prevented the deposition of fa in the livers of diabetic dogs and of rats on a hig fat diet. Choline, it should be stated, has a wide dis tribution in the body as a constituent of lecithi and sphingomyelin. The protective action of cholin against the hepato-toxic effects of various dietar procedures has been observed in rats since then b numerous investigators. Thus Blumberg and Mc Collum[6] noted that choline prevented the develop ment of hepatic cirrhosis when added to cirrhosis producing diets, and concluded that its beneficia effects resulted from its lipotropic activity. Györg and Goldblatt[7] reported that the addition of cholin in small amounts to their cirrhosis-producing diet, re duced the incidence and severity of the liver injury Similar results were observed by Daft and his co workers,[10,14] by Lowry and his associates,[15] b Lillie,[11] and by Hough.[16] Russakoff and Blum berg[17] gave supplements of choline chloride up t 6 Gms. daily to 9 patients with clinical evidence o decompensated portal cirrhosis of the liver. Seven o the nine patients showed definite improvement, an 2 failed to improve.

Inositol is a sweet crystalline substance tentativel included in the vitamin B complex. It occurs i muscle, brain, red blood cells and eye tissue, and i distributed throughout the plant kingdom.[18] I causes regression of mouse alopecia,[19] cures spec tacled eye in rats,[20] increase intestinal motility i dogs,[21] and causes a growth increment in th chick.[22] In the present study the lipotropic effec of inositol merits special emphasis. Gavin and Mc Henry[23] have shown that inositol has a lipotropi effect on the fatty livers of rats receiving a hig carbohydrate, low protein diet and biotin. Thi lipotropic action of inositol has been confirmed b

Forbes[24] who significantly found that the effect of inositol plus choline was considerably greater than that of either alone. It is this work of Forbes which suggested the combined use of choline and inositol in the treatment of human cirrhosis of the liver. Abels and his co-workers[25] reported that the lipotropic action of lipocaic could be accounted for by its content of inositol alone. This finding was based on a study of patients with gastro-intestinal cancer who were given inositol preoperatively. Vorhaus and his associates[26] in 1943 reported that human subjects were given 1 or 2 grams of inositol daily without any apparent harmful effects. Patients with alopecia were so treated without beneficial results, while variable responses were obtained in patients with chronic bilateral skin eruptions of unknown etiology. Shay,[27] commenting on this report, stated that he had given inositol to diabetic patients, particularly to those with enlarged livers, in doses of 1.2 grams daily for a considerable period without producing changes in the blood cholesterol levels or in the size of the liver.

## CASE REPORTS

During the past year we have had the opportunity of supervising the care of four patients with cirrhosis of the liver. Before oral treatment with choline, or with choline combined with inositol, all patients were subjected to a complete history and physical examination and the following laboratory procedures: Complete blood count, urinlaysis and urinary urobilinogen determination, bromsulfalein liver function test (in the absence of jaundice), hippuric acid test, oral galactose tolerance test, icteric index, serum protein and albumen-globulin ratio, cholesterol and cholesterol-esters, alkaline phosphatase, prothrombin time and serologic test (Kline) for syphilis. Abnormal initial determinations were repeated when indicated. After discharge from the hospital all patients were seen at frequent intervals, and were provided with sufficient amounts of the therapeutic agents to maintain them until the next scheduled visit. The total duration of treatment is indicated in each of the following case reports:

Case No. 1: W. L., white male, age 33, had consumed one quart of liquor daily for the past 15 to 20 years. During sustained drinking bouts he often ate no food for a week at a time. One year before admission he noted enlargement of his abdomen. This was progressive and later was associated with lower abdominal pain. He developed jaundice one month before admission and had an episode of epistaxsis during the previous week. Other complaints were an intolerance for fatty foods, flatulence, anorexia, nausea, vomiting and one attack of hematuria. When first seen on April 5, 1944, he was acutely ill, partially stuporous and markedly icteric. His nares were plugged with cotton which he had used to control a nasal hemorrhage. The teeth were in poor repair and blood clots were present in the posterior pharynx. Spider telangiectases were observed on the face. Numerous dry and moist rales were present in both lower lung fields. The heart was slightly enlarged to the left. The rhythm was regular, the rate normal and a non-transmitted systolic murmur was heard over the pulmonic area. The breasts were not enlarged. The abdomen was protuberant and shifting dullness was easily elicited. The non-tender, nodular liver was enlarged five finger breadths below the right costal margin and tenderness was noted at the left hypochondrium. Collateral venous channels were prominent superficially over the anterior abdomen and lower chest. Scattered ecchymotic areas were observed in the skin of the lower extremities. Hemorrhoids were absent. Radiograms of the chest disclosed an elevated diaphragm, prominent vascular markings and slight enlargement in the region of the left ventricle. A gastro-intestinal series revealed an enlarged liver and spleen, and ascites. Studies of the peripheral blood and urine were negative. Other laboratory examinations resulted in the following abnormal findings: Serum protein 5.5 Gms. per 100 cc., serum albumin 4.2 Gms. per 100 cc., serum globulin 1.3 Gms. per 100 cc., icteric index 53, Weltman coagulation band 10.

The patient was treated with ammonium chloride and received two injections of salyrgan to promtote diuresis. He was placed on a high protein, high carbohydrate, low fat diet with supplementary vitamins A and D and received 4 Gms. of Choline daily in divided doses. Marked subjective and objective improvement resulted. The stupor disappeared, the jaundice slightly regressed and his appetite and general state of well being improved. Three and one half weeks after treatment was started, the icteric index was 25, Weltman coagulation band 7.5, total serum protein rose slightly to 5.9 Gms. per 100 cc. and serum globulin to 1.9 Gms. per 100 cc. He was discharged from the hospital on April 27, 1944 and instructed to continue on the above diet. He was given sufficient choline to last one week on a dosage of 4 Gms. daily and was instructed to report at weekly intervals at which time his supply of choline was replenished.

Two months later he had gained fifteen pounds in weight, his nausea, belching, vomiting and constipation had all disappeared. At this time jaundice was absent, the lungs were clear, the pulmonic systolic murmur could not be heard, the abdomen was considerably smaller than on admission, there was no evidence of ascitic fluid and the degree of collateral circulation had markedly diminished. The liver was still partially palpable and slightly tender beneath the costal margin.

At this time the patient stated on questioning that he had had no desire for alcoholic beverages while observing the dietary and choline regime. Without the patient's knowledge, a simple syrup was substituted for the choline and he was told to report again in a week. One week later he returned stating that he was "jittery" and had experienced great difficulty in restraining imbibing alcohol. Choline was then substituted for the syrup and within a period of two

days his "jittery" feeling had disappeared and he stated that he had lost all desire for alcoholic beverages. The patient was restored to his normal activities and returned to work. He had taken 4 Gms. of choline daily from April 10th to September 21, 1944, with the exception of one week when a simple syrup had been substituted. Improvement in this patient was demonstrated by the disappearance of jaundice and ascites, the diminution in bleeding tendency, the gain in weight, the increase in general well-being, the diminution in size of the liver, the improvement of serum protein, the drop in icteric index to normal and the decrease in the Weltman coagulation band.

Case No. 2: F. B., white male, age 35. This patient had imbibed alcoholic beverages to excess over many years and often abstained from food for periods of time up to two weeks. In 1942 he noted yellow coloration of his eyes and skin accompanied by pruritis. These symptoms recurred in 1943 and again one month before admission. During these episodes he experienced flatulence, belching, slight loss of weight and complained of pain in the right and left upper quadrants. He had had one episode of hematuria and was informed by his physician that he had hemorrhoids. When seen on May 8, 1944, he was moderately ill and icteric but there was no evidence of spider telangiectases. His head and neck were negative, his chest was clear and his heart was not remarkable. The liver was exceedingly tender to palpation and reached to a level three finger breadths below the right costal margin. The tip of the spleen was palpable on deep inspiration. Ascites was absent but internal and external hemorrhoids were noted. A gastro-intestinal series revealed a large liver and spleen and a gastro-duodenitis. Blood studies showed a mild hypochromic anemia. The urine was negative. Other laboratory studies disclosed the following abnormal results: Alkaline phosphatase, 11.6 Bodansky units; icteric index 17; total serum protein 5 Gms. per 100 cc.; serum albumin 3.3 Gms. per 100 cc.; serum globulin 1.7 Gms. per 100 cc.; 9.5 Gms. of glucose were excreted during the performance of the galactose tolerance test.

The patient was placed on a high protein, high carbohydrate, low fat diet with supplementary vitamins A and D. In addition he received 1 Gm. of choline four times a day. After eighteen days on this routine the alkaline phosphatase had dropped to 1.4 Bodansky units, the icteric index was normal. The patient's appetite was markedly improved and he had gained sixteen pounds in weight. One month later he showed continued symptomatic improvement. He failed to keep his next appointment and was seen on the street five weeks later. At this time he stated that following trouble at home he had stopped taking choline and had begun to drink heavily again. This had continued for a period of four weeks. He was admitted to the hospital the next day complaining of anorexia, itching of the skin, nervousness and insomnia. Physical examination revealed deep icterus, considerable loss of weight, marked tremor of the hands, a tender, palpable liver but no ascites. The icteric index at this time was 44 and the phosphatase 2.7 Bodansky units. He was given the same therapy as previously. Five days later his icteric index had dropped to 17. Two weeks later he stated that he had completely lost his desire for drink and had gained eight pounds. He had no gastro-intestinal symptoms and his icteric index was 9. With the exception of 4 weeks when he had voluntarily discontinue the use of choline, he had been taking this therapeutic agen daily between May 11 and October 3, 1944. Improve ment in this patient was evidenced by the disappearance o jaundice, the gain in weight, the fall in icteric index t normal, the return of alkaline phosphatase to normal valu

Case No. 3: G. F., white female, age 40. This patien was under the care of a local physician for cirrhosis of th liver since 1940. She had been drinking from a pint to quart of alcoholic beverage daily for the previous ten years Occasionally she had abstained from foods for periods u to one week. She was first seen in 1942 because of abdomina pain, swelling of the abdomen and a weight loss of 3 pounds in the previous two years. At this time her head neck, heart and lungs were not remarkable, her abdome was rotund and distended, the liver was palpable below th costal margin and shifting dullness was elicited. The urin was negative but there was a severe hypochromic anemia The patient was placed on a low fat diet. Salyrgan to pro mote diuresis was instituted and an abdominal paracentesis performed. Six months later she was again admitted for a paracentesis. The liver was now markedly enlarged, th anemia had not improved and the patient was in poor gen eral condition. She had continued her habit of drinking.

In the spring of 1944 she was referred to the authors fo treatment. At this time she complained of malaise and con stipation, with occasional attacks of nausea and vomiting and bouts of epistaxis. Frequently her gums bled freely. I was her opinion that her abdomen was slowly becoming larger. She had stopped drinking during the previous year. Physical examination at this time showed no jaundice. Her heart and lungs were clear, her liver was at the level of the umbilicus and her spleen was barely palpable below the left costal margin. Shifting dullness was elicited on abdominal examination. She had internal and external hemorrhoids. Blood and urine studies were negative. The only abnormal liver function test was the prothrombin time of 31 seconds. A gastro-intestinal series showed an enlarged liver and spleen and a possible varix at the lower end of the esophagus.

She was placed on a high protein, high carbohydrate, low fat diet with supplementary vitamin A and D and was given 1 Gm. of choline and 1 Gm. of inositol six times a day. After two days of this therapy, her prothrombin time had dropped to 19 seconds and she was discharged from the hospital with instructions to continue taking the choline and inositol.

Two months after discharge, the malaise and constipation had disappeared. She had gained 13 pounds in weight and the bleeding from the gums was diminished to absent. The liver at this time was still palpable but much smaller than on her earlier examination and the spleen could not be felt. Signs of ascites were absent. During this two months period the prothrombin time had varied from 13 to 25 seconds on three different occasions. While taking choline and inositol she stated that she had experienced no desire to drink alcoholic beverages and had refrained from imbibing them. Choline and inositol therapy had been continuous between May 11th and September 21st, 1944. Clinical improvement in this patient was demonstrated by gain in weight, disappearance of malaise and constipation and ascites, diminution

in bleeding tendency, reduction in size of the liver and return of prothrombin time to normal.

Case No. 4: E. J., white female, age 55. This patient was admitted to the New Britain General Hospital on April 9, 1944 for repair of a cystocele, rectocele and lacerated pelvic floor. Her second and last pregnancy had terminated normally 27 years before admission. One year, and again three months before admission, she had experienced attacks of painless jaundice each lasting approximately one month. With the exception of an occasional bout of epistaxis she denied any bleeding tendency. She also had observed no nausea or vomiting and had maintained her weight. She did not indulge in alcoholic drink and denied having taken any of the known hepato-toxic substances about which she was asked. At the time of the first episode of jaundice, a gall bladder series showed the presence of a normally functioning gall bladder. Twenty days after the surgical repair of her pelvic floor her physician noted the presence of ascites. Two abdominal paracenteses, totaling 9,800 cc. of yellow, cloudy fluid with specific gravity of 1.013, were performed within the first week after the discovery of her ascites. The fluid contained no tissue fragments or isolated cells suggestive of a malignant process.

Physical examination one week after the onset of ascites revealed a comfortable patient with no spider telangiectases of the skin. The head and neck were negative. A few fine rales were heard posteriorly over the right lung base. The heart was essentially normal. The left lobe of the liver was palpable just below the right costal margin. It was smooth and non-tender. The spleen was not palpable. The following abnormal laboratory findings were disclosed: Total serum protein 4.9 Gms. per 100 cc., serum albumin 2.3 Gms. per 100 cc., serum globulin 2.6 Gms. per 100 cc. She excreted 15.4 Gms. of glucose during the performance of the galactose tolerance test. A gastro-intestinal series showed dilatation of the esophagus with slight narrowing at the lower end and irregularity of the mucosal pattern suggesting esophageal varices. The chest plate was not remarkable.

The patient was placed on a high protein, high carbohydrate, low fat diet and was given choline, 4 Gms. per day, together with supplementary vitamins A and D and a single infusion of 250 cc. of plasma. One week later the galactose tolerance test was normal, the serum albumin was 2.4 Gms. per 100 cc. and the serum globulin 2.8 Gms. per 100 cc. At this time there was no ascites and the patient stated that she felt much better. Two weeks after this examination, ascitic fluid was again demonstrable and the abdomen had increased in size. She was continued on her choline regime but ammonium chloride and mercupurin were given to promote diuresis. By May 31st she had gained 10¼ pounds most of which was probably due to the ascitic fluid. Because of the continuance of the ascites, the doseage of choline at this time was increased to one gram 6 times a day and in addition she was given one gram of inositol 6 times a day. From this time on her ascites began to diminish, her appetite remained good and she felt much improved. On May 27, 1944, her total serum protein was 5.9 Gms. per 100 cc., the serum albumin 3.4 Gms. per 100 cc., serum globulin 2.5 Gms. per 100 cc. Symptomatically she was much improved and there was a marked decrease in the size of her abdomen although a small amount of fluid was apparently still present. This subsequently disappeared entirely. She had taken daily doses of choline from May 12 to November 4, 1944. Clinical improvement in this patient was demonstrated by the return of appetite and general well being, the disappearance of constipation, the increase in total serum protein, the gradual disappearance of ascites and the correction of the inverted albumin globulin ratio.

## DISCUSSION

In our experience choline alone or in combination with inositol produced regression or complete disappearance of the symptoms and signs resulting from hepatic cirrhosis. It appears probable that the improvement was the result of the lipotropic activity of the therapeutic agents, and that little if any regression of the fibrotic liver changes resulted. If this surmise be true, clinical improvement can be expected to run parallel to the degree of fatty change in the cirrhotic liver, and to bear an inverse ratio to the amount of fibrous tissue deposits. Evidence for this view is suppied by the observations of Russakoff and Blumberg.[17] Of the two patients who failed to improve under their choline regime, one had an enlarged fibrotic but non-fatty liver at autopsy, and the other had a small shrunken liver.

Choline exhibited orally in 6 gram daily doses for several months in no instance produced any reaction, transitory or enduring, which could be described as a toxic effect. We have not atempted to define the toxic range of choline in man, but in rats the L.D. 50 following administration by stomach tube has been found to be 6.7 Gm./kg.[28] Inositol similarly has produced no toxic effects or side reactions in the given doses which were as much as three times the amount employed by Vorhaus.[26]

Because the number of patients available for study in this institution is limited, we were unable to compare the effects of choline and inositol in combination, with the results obtained by the use of either alone. In Case No. 4 however, there is suggestive evidence which tends to confirm the findings of Forbes, that inositol combined with choline was more effective than choline alone. Certainly inositol does not depress the beneficial results of choline therapy in cirrhosis of the liver. We were also impressed, in three patients, by the apparent inhibitory effect of these agents on the desire for imbibing alcoholic beverages. The sample of patients is small, and this observation may be spurious. It is hoped however, that other investigators, with larger clinical material to draw on, may be able to pursue this and other aspects of our study.

CONCLUSIONS

1. Choline alone and choline and inositol in combination, are valuable therapeutic agents in the treatment of cirrhosis of the liver.

2. Inositol does not inhibit the beneficial effects of choline in the therapy of cirrhosis of the liver.

3. There is suggestive evidence that choline and inositol depress the desire for alcoholic beverages in patients with alcoholic cirrhosis of the liver.

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# THE SOCIAL IMPLICATIONS OF SCIENTIFIC RESEARCH

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*"Experiment is the sole source of truth. It alone can teach us anything new; it alone can give us certainty. But to observe is not enough. The scientist must set in order. Science is built up with facts as a house is with stones. But a collection of facts is no more science than a heap of stones is a house."*

H. Poincaré

*"Until man rises to the fullness of his moral height and insists upon the right to perform the full task for which his abilities equip him, we shall have an eternally imperfect state whose principles swing backward and forward between two concepts of basic authority. Another 5,000 years may see either one of two things: some improvement or utter extinction. Man cannot forever quarrel with himself and survive."*

Arthur C. Parker

WE ARE assembled today to honor the memory of one of Canada's noblest sons, for whom it is fitting that this lectureship should be established. Dr. Banting's life and work have had profound significance for the human race. He placed in the hands of doctors means whereby the horrors of one of nature's most feared scourges could be mitigated. Countless victims of diabetes the world over are now happily living, and an even greater multitude yet unborn may well rise to bless his name. Doctors in every land will ever revere his memory. Only one who has watched a victim of diabetes gradually fail from exhaustion and die in a state of profound stupor, often lasting for several days, can appreciate the miracle of insulin. It is with a deep sense of humility that I approach the task of addressing you, for the opportunity of participating in these exercises is indeed a high privilege.

Dr. Banting made two contributions to medicine which entitle him to distinction: first, the isolation of insulin; second, his stimulation of scientific research. The importance of the latter is not fully appreciated. Several medical discoveries of vital importance to humanity followed soon after the isolation of insulin. The impetus for many of these investigations can be traced directly to Dr. Banting's influence. The value of research, therefore, is a proper theme for consideration at this time. It was the subject closest to Dr. Banting's heart. He was one of the first to realize that it was his country's greatest need. He deplored the fact that each year large numbers of young Canadians were migrating to other countries because opportunities for special study were lacking in his homeland. The idea gripped him with patriotic fervor. The discovery of insulin seemed to him but an incident in his career. His real mission was to promote and stimulate research in the field of medicine. For him there could have been no more appropriate reward than the founding of the Banting Institute for Medical Research.

Man is one of the oldest, and yet, from a physical point of view, one of the poorest equipped animals on earth. His superior intelligence accounts for his survival because it has enabled him to insure an adequate food supply and protection against the destructive forces in nature. Indeed, the most potent enemies of the human race have been man himself and parasitic disease.

Eolithic man, or the dawn man, appeared before the first glacial epoch upwards of 350,000 years ago. If the distance which he has traveled since be represented by six miles, the date 4241 B. C., when he made his first recorded scientific observation, would be only six inches from the end of the line. That is to say, the Egyptians in 4241 B. C., from long continued observations of the movements of the heavenly bodies and from accurate records of these observations, had drawn the conclusions of a 365-day calendar year and the knowledge of the need for an occasional adjustment of one day. Accordingly, in this six mile pathway of his existence man traveled

*The Banting Memorial Lecture delivered before the Faculty of Medicine of the University of Toronto, February 21, 1944*
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all but six inches of his six miles before he made his first known and recorded scientific deduction. He then continued along his six mile pathway to within two inches of the end before he seriously began to examine nature from the scientific point of view. To evaluate more definitely the development and use of the scientific method in the historical period, let us construct another line dating from this first known recorded scientific observation, the calendar year in 4241 B. C. Since then, 6,185 years have elapsed, which may be represented by a distance of, roughly, 500 feet. Along this new pathway of 500 feet he would have traveled 496 feet before he reached the point where active scientific research began. Indeed, much of it would begin less than two feet from the end, or the present day. These figures convey graphically how recent is the application of the scientific method to human needs.

From the dawn of his career down through the countless ages, man has had no adequate explanation for the vicissitudes of nature which have either favorably or unfavorably affected his destiny. The phenomena of life and death have been a mystery which has ever defied his metaphysical reasoning and speculation. Now and then through the centuries a philosopher has appeared who by experiment has attempted to illuminate the unknown. But this type of thinker has not been looked upon with favor. He has been discouraged and repressed. Education and culture for centuries were regarded as the special province of the schools and the church, both of which looked askance at the intrusion of science.

One of the first who dared experiment was Leonardo da Vinci, who, less than five hundred years ago, said, "The interpreter of the artifices of nature is experience, who is never deceived. We must begin from experiment and try to discover the reason." About two hundred years later, in the seventeenth century, a group of remarkable men appeared who began to use the experimental method. Their crude beginnings were the founding of modern science. They worked in the face of insuperable difficulties, often suffering martyrdom. Galileo was one of the first to use the experimental method. He studied the rate of falling bodies from the leaning tower of Pisa in 1589, and in 1611 invented the telescope.

While the Arabs are credited with the invention of our system of numeration, mathematics and the sciences based on that subject received great impetus from the work of Napier, who in 1614 published his work on logarithms. Three years later, Henry Briggs improved Napier's work by devising the system of decimal notation. During this historic period, trigonometry and algebra were developed analytical geometry invented, differential calculus perfected, and the law of gravitation discovered. These profound contributions were basic to the later discoveries in the field of physics and chemistry. The immortal Harvey, who discovered the circulation of the blood in 1628, was the founder of modern experimental medicine. Since then the number of investigators has grown and the field of inquiry and experiment broadened.

For centuries, predatory man has found it easier to wage wars of conquest and plunder on fortunate and thrifty neighbors than to battle with nature and the soil. The German Reich's Lebensraum means only that it covets the rich grain producing lands and natural resources of other nations. However, today throughout the world, millions of people are either dying of starvation or living on subnormal subsistence. Recent reports tell of terrible famine conditions in China and India. There are countries, notably Japan, which are overpopulated, their inhabitants living in cruel poverty. Still other nations have no homeland. Yet there is an abundance of arable land on the earth awaiting only its development by man.

In the vast areas of South America drained by the Amazon and the Orinoco are lands lush with fertility. The same is true of the great regions of Africa drained by the Nile, the Niger, and the Congo. The development and use of these millions of square miles of forest jungle are made difficult or impossible at present by the myriads of insect and parasitic pests which are highly destructive to human life. Homelands of wealth and luxury on both of these continents for nations as large as Britain or the Untied States await the scientific research and resourcefulness of man.

How illogical and absurd is it for civilized peoples to engage in terrible wars of conquest for the specious reason that more living space is required, when there is so much of the earth's surface that is not being used. What is true in this respect of South America and Africa is in large measure true of the other continents. Hunger and disease are the greatest foes of man, and, if he had any sense, man would recognize the fact and change his fighting front and tactics. The solution of the problem is one of scientific research. The world awaits another Gorgas and another Ross who, with the money which a single modern battleship costs, might find the answer.

It is comparatively easy to determine the food

needs of a nation, but more difficult to estimate the total agricultural production necessary to supply optimal food consumption. It has been conservatively estimated that if all the good agricultural land in the world were to be cultivated by the best modern means it could adequately feed the total population of the world from two to twenty times over. In a study of nutrition in Britain, a relatively favored country, prepared before the onset of the present war, it was revealed that half of the population suffered from deficient feeding and that one-fifth were below even minimal fitness and state of health. It is estimated that it would require not less than 20 per cent more food than the British people now get to bring the whole population up to a normal standard. This is roughly three times more than the agricultural production before the war. Assuming the present population of Britain to be 44,000,000 and the prewar cultivated area to be 12,000,000 acres, it would mean that a productive land area of 36,000,000 acres is needed to supply Britain's food. This is approximately an average of one acre per inhabitant. I am aware that in the present war emergency soil cultivation in Britain has been increased and that food supplies are diminished. Using this British standard as an index, two billion acres would be needed to supply the inhabitants of the whole world with an adequate food supply. This two billion acres, however, is less than half of the present cultivated area of 4,200,000,000 acres; and this, in turn, is only 12 per cent of the land surface of the world.

It is proper to ask why are these enormous areas uninhabited by man? The answer is mainly disease. Civilization had its origin in the tropics, but it was disease that drove man out to the colder temperate and arctic zones. Contrary to the former belief, General Gorgas, in his studies of yellow fever, proved that the white man can live with unusual vigor in the tropics, and also that while in the temperate zones man can with much labor grow but one crop a year, in the tropics he can raise two or even three crops a year and with less labor.

In the great emergency today, scientific research is being actively promoted by all the warring nations, but prior to the onset of the conflict it was less highly regarded. For example, Britain begrudgingly devoted one-tenth of 1 per cent of its national income to research, which is only 3 per cent of what is spent on liquor, 2 per cent of what is spent on tobacco, and 1 per cent on gambling. The United States, with greater wealth, devoted 0.6 per cent of its total income to research, but was more profligate with the vices. The Soviet Union, with broader vision, devoted 0.8 per cent of its income to research, and in addition placed it on a far more efficient basis.

Let us see what research has accomplished for Russia. It should be remembered that Russia, culturally, is a very old nation. The University at Kiev was established more than a thousand years ago; yet for the most part under the Czars, Russia practically stood still up to the present century. An English investigator recently stated that Russia socially and intellectually in 1914 was at the cultural level of England in 1800, but that in the succeeding twenty-five years she had covered as much ground as had Britain in a century. Regardless of our views as to the implications of Russia's political philosophy, the student of scientific research would do well to study her achievements. As stated, the Soviet Union is devoting a far larger share of her total income to scientific and social research and education than any other nation in the world, ten times that of Britain, and 40 per cent more than the wealthy United States. Most of what has been accomplished is the result of less than ten years' efforts. At the end of the first World War, Russia's large scale industries were practically destroyed, less than one-seventh of the prewar state. By 1925, they had reached three-fourths of the prewar level, but still were small. At the end of 1937, Soviet industry exceeded that of Great Britain and Germany, and was second only to the United States.

For example, in a little unheard of region in the heart of Asia is located the Kirghizian Soviet Republic, covering an area of about one-third the size of Ontario and with half the population, which was almost entirely nomadic. It is surrounded by high mountains and traversed by deep river valleys. Until recently the country was inaccessible to travelers, for there were neither highways nor railroads. Fifteen years ago there were fewer than twenty-five miles of roads over which an auto could pass. Today there are more than 2,500 miles of motor highways. The country has become a beehive of industry, with great power plants, mines, sugar refineries, cotton mills, packing plants, and an enormous agricultural development. Where formerly they had none, they now have 1,500 schools, six higher institutions of learning attended by 300,000 students. All this is the result of recent scientific and social research.

The Turkmenian Soviet Republic is another example. Twenty-five years ago it was a poverty stricken borderland. Only 1½ per cent of its people

attended school. It is now one of the leading Soviet states. Industrial and scientific research have revealed vast natural wealth. In this one state fifty research institutions have been established, employing five hundred scientists. These embrace botany, zoölogy, mineralogy, and industry. One institute is studying the problem of the practical utilization of the heat of the sun, especially important in water-distilling devices for arid areas. They have an institute of history, languages, and literature. They have created a grammar for the native language and also published two dictionaries. The capital city, Ashkabad, possesses a fine oriental museum.

In the far north within the arctic circle, wonders have been achieved in making this area habitable to man. Fuel deposits and mineral wealth have been discovered and developed. New sources of food have been found. The result is that what hitherto had been a vast desolate waste has now become the home of a vigorous people of industry and education. In the extreme south, research in plant breeding has been carried on with equally remarkable results. Progress has been made in the hybridization of tropical fruits like the citrus, and textile fibres like cotton, producing types which will grow in the cooler warm-temperate and semitropical areas.

In the Soviet Union, there are sixty national groups, each with its own language. In addition there are a large number of tribal dialects with no written language, grammar, or alphabet. Research students in the field of education have now remedied this condition. Over nine billion books have been published by the Soviet Union. Books are being published in one hundred languages, including forty which until recently had no alphabet. More copies of the works of Darwin and Shakespeare are printed and read in Russia than in Britain or the United States.

One could dwell at length on the achievements of the Russian medical scientists, but time will not permit. No country in the long history of civilization has made so much progress in so short a time as has the Soviet Union. And it has been achieved by the application of wisely directed, properly coordinated, liberally supported, scientific and social research. These accomplishments of Russia in taking poor, illiterate, nomadic peoples of diverse race, language, customs, and tradition, and converting them into settled, prosperous, educated, industrial, and agricultural states is one of the greatest social accomplishments in all human history. Their conquest of nature in making habitable for man vast tracts of land hitherto unsuited for human life is little less notable. In their postwar planning, the great white races of the world with their vaunted spiritual, cultural, and technical resources would do well to pause and contemplate these achievements of the Soviet Union.

Practically all wars of the past have ended with peace treaties frequently motivated by hate and lust for power and dominion, to be succeeded by other wars which have terminated either in extinction of nations, or still more wars. The Soviet Union has successfully conducted a full-scale experiment in scientific and social research which should receive the thoughtful attention of future treaty makers as well as the thinking people of the world.

Let us turn now from the material accomplishments of technical and social research and give consideration to that which has to do with medical science. Every one is familiar with the great improvement in public health which has taken place in the last fifty years. The eradication or control of the communicable diseases of childhood and the water and milk-borne infections accounts for most of the gain. However, there remains a large number of so-called degenerative diseases which are still largely unsolved. These include cancer, the cardiovascular-renal diseases, and the disorders of the endocrine glands. Mortality statistics do not reveal the true picture because there is a vast amount of disabling but non fatal illness. These non infectious diseases, which today are the chief causes of death and against which we have made little progress, offer an unlimited field for medical research.

How should this task be approached? At the present time, a large part of medical budgets is expended in treating afflicted patients, a considerable portion is spent in clinical research which consists in observing and classifying the passing phenomena of the disease, a sort of factual or statistical compilation which may or may not contribute to the elucidation of the underlying principles involved. According the Sir Frederick Hopkins, this type of research is greatly overrated as a scientific procedure. He believes that, if progress is to be made, the emphasis should be placed on pure research and in the newer fields of science, namely biophysics and biochemistry. He goes on to say that descriptive and morphological studies of disease structures serve mainly for purposes of classification and that studies of function and the endeavor to correlate this with structure, too, have limited usefulness. We must go far beyond these stages of investigation, however,

and look beneath the surface of the cell and think in terms if molecular events. He postulates that, in the future, disease will be viewed from a new standpoint and that even now those who think in terms of molecular events may have visions of progress denied to those whose thought is guided by the visible alone.

We are now entering a new era in which it is to be hoped that scientific research, including that which has to do with medicine, will be the main function of the worker who will possess the requisite preliminary training and will be afforded the facilities for continuing progress. In such a program, pure or abstract research, the study of principles, will play a much larger part than it now does, and less attention will be paid to the so called practical studies, the gathering of ever changing facts.

Research of the future, to be effective and useful, should be planned as a long range project to be undertaken only by those with the proper training who are willing to dedicate years of their lives to efforts which may prove to be fruitless. It, of course, must be well conceived and well supported. We should encourage those who are best fitted for the purely scientific work, and we should also try to bring the practical results of science into the lives of our people. We should teach them to think objectively in terms of science and, as we succeed in so doing, fads and "isms" will disappear. Everyone should know as much about science as possible as it affects him individually.

The physician in such a plan would serve a dual function. He might serve as a sort of assistant to the pure scientist, observing and recording phenomena in his daily practice; secondly, acting as an interpreter of science to the public at large. Many schemes for the improvement of medical care have been proposed under the name of socialized medicine, but I am confident that that one which promotes the extension of research and provides for its broadest application not only will be the wisest, but it also will be the plan most likely to succeed. The valuable part the general physician can play is well illustrated by the life of Sir James Mackenzie, who devoted most of his life to general practice in the country, but who by self-training became an accomplished scientist.

Charles F. Kettering, the brilliant director of research for the General Motors Company, has an abiding faith in people of ordinary abilities. In a recent radio address, he said:

"Intellectual prodigies are rare; each generation produces some, but most of the world's work is done by people like ourselves with just ordinary abilities who may reach positions of excellence or responsibilities by practice, study, and plain persistence. More is accomplished when men work in groups or an organization. There is nothing magical about research. It is not necessary to have expensive apparatus or elaborate buildings. Actually, research isn't a physical thing at all, just a state of mind. It is an intense desire to do something. The process is so simple that anyone can do research anywhere, at any time. First you select the problem you would like to solve. Then you list ten obstacles that may be encountered. In picking the problem, be sure that it is worth the effort. It takes just as much effort to solve a useless problem as a good one. Next you start testing the ten obstacles that you must overcome. Take the easy ones first, and by a process of elimination you at last arrive at the one or two major obstacles. You may need some apparatus for these, but the things you will probably need most are infinite patience and persistence. Few people realize how difficult it is to do any new thing and they quit before the job is finished. We get discouraged too easily. In school we are examined two or three times a year. If we fail, we are out. In contrast, most research is 99 per cent failure, and if we succeed once, we are in."

I have quoted Mr. Kettering at length because his leadership in the field of industrial research has brought about remarkable achievements. Leadership is important beyond exaggeration. The selection of leaders is perhaps the greatest accomplishment of all. Sir Humphry Davy once said his greatest discovery was Michael Faraday. And Davy himself is said to have been the chief discovery of Benjamin Thompson, or Count Rumford. History is full of similar examples.

The great technical industries of America owe much of their success to research. All of them watch the progress and inclinations of the students in the technical schools. Any boy who shows evidence of promise even in his freshman year is encouraged in practical ways. The industries are particularly interested in well trained young men. It is their experience that the mind of youth is more flexible, imaginative, more vigorous, and more amenable to direction. Old men are eased out or put into positions where they may not retard progress. None of these companies looks for geniuses, but rather for young men of good training and with the aptitudes for

scientific work. If a genius is discovered, it is a piece of rare good fortune.

I have dealt at length with this analogy from industry because I believe the same principles can be applied with equal force to the science of medicine. It is the task of the university, the medical school, and the medical profession to raise the standards of medical practice and to conquer or solve the several dreadful maladies which impose such a burden on humanity. The university is confronted with the problem of preparatory education. Is the plan which we now follow a wise one or the best? The experiment which Dr. Robert M. Hutchins is undertaking at The University of Chicago is an intriguing one. Time will not permit a discussion of his views or the methods employed. It is sufficient to say that he believes there is much waste of time and effort, and misdirection in our current educational programs. Briefly, he believes that students should be taught to think about the most important questions, the aims and possibilities of human life and of organized society. His curriculum is composed of the great books, the great experiments, and the liberal arts, that is, language and mathematics. He holds that preliminary collegiate education should be begun and completed at a much earlier age than it now is. Under such a plan the student would begin his professional training and enter a career earlier in life with greater vigor and enthusiasm.

To return to the problem of the improvement in medical practice, it would seem in the light of recent experience that the first step is the promotion of research as rapidly, as extensively, and as wisely as possible. This should be done through the universities and their medical schools in cooperation with organized medicine. Research as a permanent career for young men should be provided and encouraged. Next, the value of such research should be carried to the people in a never ceasing program. The scientist should be willing to come down from his ivory tower, unbend, and discuss his work with the common folk because they make up the bulk of the population and pay most of the taxes. An idea or an institution can have no greater stimulus or support than the interest of the common people. The practising physician should enjoy the confidence and give such assistance as may be possible to the research movement. He should be the scientific interpreter to the public. His affiliation with a university research activity would add dignity to his stature and breadth to his training. He would be more of a thinker and less of a dispensing clerk. This education of the public and the doctor in the significance of research would also have its value in gaining the support of politicians or officials in charge of the appropriation of funds. One cannot expect enthusiastic financial aid from administrative officials for the support of a nebulous project of which they know nothing and in which they have no interest.

Four years ago, we undertook an experiment in Rochester which merits a brief description. The Academy of Medicine established a medical museum for the purpose of illustrating current medical progress. For purposes of guidance, technical and material assistance, it was made a division of the Rochester Museum of Arts and Sciences. The faculty members of the University of Rochester Medical School and the Department of Public Health became active supporters.

The method of operation was as follows. In a large room in the Academy, especially built and equipped for the purpose, exhibits of various kinds are prepared illustrating investigations under way or completed, or new conceptions of old problems. At the beginning of the year, the committee in charge, after a preliminary survey, decide what problems could best be presented. Often the subjects selected related to the themes to be given as lectures by distinguished guest speakers during the season. For example, on one occasion diseases of the heart was chosen. A committee of more than twenty doctors was selected under the leadership of a qualified specialist. This group spent several weeks in preparation. One subcommittee developed the history; another arranged exhibits of literature; others dealt with pathology, diagnostic methods, and therapeutic procedures. Running concurrently were other exhibitions and demonstrations. In one year, one hundred and eighty-five doctors participated in this museum activity. These exhibits have an interest value in point of time of about two months, during which all of the doctors of the community have an opportunity of examining and studying them several times. They are then replaced by other exhibits or demonstrations. On advertised dates, the museum is open to the public, and the exhibitors act as guides or docents. Medical students, interns, dietitians, nurses, boy scout groups, hygiene classes from schools, teachers, and social workers are invited when the exhibits have special interest for them. We have found by experience that both the public and the medical profession are more interested in the museum than they are in the platform speaker. In fact, we find it necessary to close the museum in

order to get an audience for the lecture. It is interesting, too, that we have had a good deal of voluntary financial support from laymen. Unfortunately, because of lack of fuel and for other reasons brought about by the war emergency, we have not been able to operate the museum during the past year. This undertaking is purely an experiment. It is too soon to evaluate its worth.

A final word about the museum room. It is really beautiful, having been decorated for us by the Federal Arts Project. Around the side walls next to the ceiling runs a frieze made up of twenty-six panels. On these are engrossed the names and deeds of scientists of North America who have made notable contributions in the field of medicine. On one of these panels appear the names of Banting and Best; on another that of Osler. At the far end of the room is a large mural which depicts some of the great characters of history, including Pasteur, Jenner, Lister, Osler and Banting. In one part of the mural is shown suffering humanity, and in the other, science wrestling with the problems of disease.

I have been told that it is contemplated to have a memorial room for Dr. Banting in your university. I can think of no more useful one than a teaching museum which would carry the message of medical science to all the people.

Everyone now is looking forward to the sucessful termination of the present terrible war. At its conclusion the people of the whole world will be faced with the problem of reconstruction. We shall be concerned not only with our own problems, but also with those of our enemies. We shall have vanquished the armies of the Axis nations, but the two greatest foes of man, starvation and disease, will remain unconquered, later to tempt and lead man to other and more ferocious wars. Let us hope and pray that those who direct our destinies will have the wisdom to see the value of scientific research; research directed toward the rehabilitation of the earth which has either been despoiled by foolish warring man, or is uninhabitable because of pestilence; research directed toward the eradication of disease which cripples or destroys such a large part of our useful population. In this the medical profession should play the leading part. Physicians should not be the subordinates of social workers or political directors. They should be the interpreters of medical science and the leaders in public health movements. They should be the missionaries and proponents of medical research. The doctor and the research scientist, thus working hand in hand, could contribute much to the future happiness and security of mankind.

I feel strongly that this thought was ever in the mind of Frederick Banting. I am sure that his spirit is with us today and that this message has his approving benediction.

His was a great soul. His memory will never die.

"They are not dead who live
In hearts they leave behind.
In those whom they have blessed
They live a life again
And shall live through the years
Eternal life, and grow
Each day more beautiful
As time declares their good,
Forgets the rest, and proves
Their immortality."

—Orr

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# EDITORIALS

## Medicine, Research and the Public

Medicine faces today one of the most important eras in its history. The rapid growth of insurance plans for hospital service and for medical care is striking and impressive evidence that a public awareness of Medicine in its relation to the community now exists which is unprecedented. It is apparent that there is a real consciousness of the value and the efficiency of modern methods in the care of the sick and such response contains some measure of flattery to the profession, for it is we who have emphasized for a long time the many advantages offered by newer and improved methods of medical care.

The brilliant achievements of Medicine during wartime, both abroad and at home, have resulted also in a certain public appreciation, as revealed through the press and similar agencies, which has never before been realized, and the courage and sacrifice of physicians with our troops is one of the fine inspirations of the war.

That a world in upheaval by a general war is experiencing at the same time vast changes in many social structures is not to be denied and that medical practice as we now know it will share such changes seems unquestionable. In the field of research some of these trends are considered by Dr. John R. Williams in the Banting Memorial Lecture entitled "The Social Implications of Scientific Research," which we are pleased to print in this issue of the JOURNAL. Incident to the war, scientific research in many fields has expanded greatly and it may be said that without the search for new knowledge modern war could not be waged successfully. In medical research great strides have been made and the future of such investigation is indeed brilliant if men of proper training and ability can be attracted to this field of endeavor. This will become possible only if

proper financial support can be established. Until the present time a large part of support for medical research has originated from socalled private sources, but it seems evident that in the future the desirable expansion of the medical research progam cannot be carried on without a much greater direct participation in support by the public itself. Some of this public support will come, as it does at present, from state and federal sources, but a more direct participation on the part of our citizens is desirable not only from the standpoint of what research can accomplish but from the important effect of its being fostered by our citizens as a public responsibility. It has been suggested that a direct means of this kind of support could come from funds derived from money paid to support health insurance plans, such as those embracing hospital and medical care. A research program along both scientific and social lines could be of direct benefit to a great group of those insured in much the same way that the great research programs fostered by industry have been of benefit to those in industry.

It is a truism that good medical care and scientific investigation go hand in hand. As physicians we can never consider properly the former in terms of service to society as something apart from the latter. In attempts to formulate plans for society to receive good medical care we would do well not to forget these words of the Banting Lecturer, "Many schemes for the improvement of medical care have been proposed under the name of socialized medicine but I am confident that, that which promotes the extension of research and provides for its broadest application not only will be the wisest, but it will also be the plan most likely to succeed."

## Seventy-Five Years of Public Health

The Massachusetts Department of Public Health recently celebrated its diamond jubilee. Beginning in 1869 when the term "public health" meant very little in this country, down through seventy-five years of pioneering and accomplishment, our sister State can now point with pride to an enviable record of accomplishment. Such leaders as Henry I. Bowditch, Henry P. Walcott, Theobold Smith, Allan J. McLaughlin, Eugene R. Kelley, and in our own generation George Bigelow, the young man of brilliant mind and energetic temperament—all have left their imprint on the public health movement in Massachusetts. The medical profession may be justly proud of its record in this important field of preventive health. The record speaks for itself.

## Whose New Home Will It Be?

At this time the new home for the Society seems a reasonably assured fact. The response to letters sent to our members by the Trustees of the Building Fund has been very gratifying. Not all replied on receipt of the first letter. Many overlooked the appeal, others took time to discuss it with their friends and to decide on the amount of their gift. Responses are coming in to the Society office from day to day. Many of the gifts have been very generous; all are received with an appreciation of the spirit which has prompted them.

There are still many members in our Society who have not responded. This failure may be intentional but is probably due to oversight or indecision. We have no argument for the physician in Connecticut who feels no obligation to help organized medicine in doing its job for the returned veteran with all the facilities necessary. He is not well informed. In the past we have presented the physical needs of the Society's office and the cold facts remain that more space is necessary. To those who have given according to their means we are grateful. To those who have not responded we would call attention to the Trustees' goal, a gift from every member in the Society, no matter how small it may be. All cannot contribute a large sum but every one can give something. It is an opportunity for each and every member of the Connecticut State Medical Society to have a vested interest in his organization which should quicken his appreciation of medicine's accomplishments and medicine's plans for protecting the best in the practice of medicine for our patients and for the physicians who follow us.

Do not let the goal of $50,000 deter you from adding to the gifts already received, whatever you decide should be your contribution. The goal is not alone a financial one. It is a numerical one and to be attained should represent every member of the Society. We owe much to our Society officers and committee members who have labored relentlessly and fearlessly for our welfare and for the improvement of medical care in our State. This is our opportunity to render tribute. We must not fail them.

## Compulsory Health Insurance

There appeared during the present session of our State legislature an unusual number of bills relating to public health and welfare. One of these bills, H601, provides for a statewide system of a compulsory health insurance. It is important for us to consider the thought which supports such legislation, for in many ways it represents thinking different from that which we have thought to be traditional in the social structure of this country. That our form of democracy, often spoken of as The American Way, may be difficult of exact definition is to be granted, but that most Americans have certain ideas about it is also true. One characteristic that has typified our society since its very beginnings on this continent has been the spirit of individual freedom. Indeed, historians tell us that this ability to stand on one's own feet was a dominant character of the Angles or Engles, even before their conquest of the British Isles. It long has been our pride that in America an individual by his own initiative could attain that recognition which his talents warranted with greater facility and sureness than elsewhere in this world. Amused as we are by the heroes of Horatio Alger, we know deep down that often they are not too overdrawn. Americans speak, not without pride, of the self-made man and it must be agreed that our system has produced leaders who have made us a nation great in the eyes of the world.

In considering any legislation aimed at changes which appear radical and which may affect those things which are basic in our social makeup, the duty of our law makers is to view not only immediate objectives but to consider what the effects may be upon those things which are inherently good in that structure. In any consideration of compulsory health insurance it would be wise if those who are proposing and supporting such measures would seek to know the advantages offered by those forms of health insurance in which the word compulsory has no application. They should realize that, as physicians and as citizens, our profession is not only concerned with preserving the individual's free choice of physician but also with his free right to choose voluntarily that form of insurance against the hazards of illness which will suit best his particular need. To this end not only has the medical profession in this country cooperated in full extent in voluntary health insurance plans, but in many states it has set up within itself the operation of non profit plans to meet the growing need. Medicine takes the position that under such insurance development not only can it continue to protect its own freedom of action, which over the centuries has been the basic factor in its great development, but also that such a system will foster in the minds of those whom Medicine serves a healthy desire to maintain the same individual freedom. A great American, William James, philosopher and physician, in speaking of his friend, the learned Thomas Davidson, once wrote, "The memory of Davidson will always strengthen my faith in personal freedom and its spontaneities, and make me less unqualifiedly respectful than ever of Civilization, with its herding and branding, licensing and degree giving, authorizing and appointing, and in general regulating and administering by system the lives of human beings."

## Medicine and the Changing Order

Out of the confusion engendered by attempts at massive social legislation it is encouraging and even refreshing to read the report issued in January by the Committee on Medicine and the Changing Order of the New York Academy of Medicine. In its resumé of the accomplishments of medicine in the past, the committee points out that "it is obvious that medicine cannot, save with great harm to all, govern its progress by consideration of profit and loss, nor can it compromise with quality. It is equally obvious that, because there is a widespread demand for good medical care for all at the lowest possible costs, medicine cannot continue to operate as it has done in the past."

The Committee points to the need for a revision of the medical curriculum and a review of premedical education with an adaption of this phase of preparation to the new conditions. Attention is called to the two immediate problems in the postwar period, graduate training for those who had to accelerate their medical education, and postgraduate courses for those who have been in the service and in many instances out of touch with advances in medical knowledge. The problem of the place of the hospital in the program of medical care is recognized. The confusion resulting from the provision of medical services by corporate bodies is touched upon.

The greatest problem of all pertains to preventive medicine. How can we make it socially effective? In the closing paragraphs of the report the committee deals with social legislation. "The belief that society is a loosely joined organism and that its seg-

ients can be deliberately rearranged according to ome preconceived pattern is widespread. The cur-ent inclination to manipulate society according to ome preconceived plan and the efforts to cure the vorld of its ills by 'massive' doses of social legisla-ion are frought with real dangers." . . . "What urgently needed is an exposition of precisely what involved, coupled with specific workable proposals hat will assure an advance toward the desired goals. The knowledge thus derived could then serve as a asis for whatever social legislation is necessary. It hould be obvious that actual experiments in various ormulas for medical care are essential before effec-ve legislation is made possible."

The Committee realizes the enormity and com-lexity of the entire problem. Further reports are nticipated in the hope that they may provide a ontribution to the solution.

## Measles Prophylaxis

Immune serum globulin (gamma globulin) for the rophylaxis of measles has been made available by he American Red Cross for use in the civilian popu-ation. Since the Red Cross is to bear the cost of rocessing and delivering the globulin, it will be urnished free to everyone, regardless of financial tatus.

The Connecticut State Department of Health has rdered a supply of gamma globulin and will dis-ribute it through local health officers in accordance vith the procedure employed for other biologics. Physicians who wish to obtain globulin are asked to onsult with the local health officer and to keep a ecord of its use on a form which he will provide.

For the present, the product is to be administered nly for the prevention or modification of measles, y the production of temporary passive immunity n persons who have been definitely exposed to the isease. An informative statement by C. A. Janeway, M.D., Harvard Medical School, on the indications, dministration and dosage has been sent out by the State Department of Health and should be helpful n familiarizing physicians of the state with this reparation which promises to be a valuable addi-ion to the list of immunizing agents.

## Fatalities Among Children in the Home

In 1942, the last year for which official informa-ion is available for the general population, there were about 4,400 deaths from accidents of all kinds among children from 1 to 4 years of age. More than half this number occurred in the home due to five chief causes: burns and scalds, ingestion of poison-containing compounds, falls, drowning, and fire-arms.

The 1,300 fatal burns from hot liquids, open flames, or hot objects could, in many instances, be prevented if children were kept out of the kitchen. Matches should be kept in a safe place out of reach of the climbing youngster.

Disinfectants, drugs, cleaning compounds and kerosene accounted for 350 fatalities. Slippery floors, loose rugs and carpets, objects left on steps pro-duced 250 deaths from falls. Firearms are a source of great fascination for the older children of teen age who are fond of rummaging through the garret or in closets. Many a boy has found his father's gun or revolver, too often loaded, and in showing it off to a companion accidentally shot himself or his youthful playmate.

The Metropolitan Life Insurance Company, dis-cussing the responsibility for these home accidents among children, places it squarely on the parents. Many physicians are parents, all deal with parents and should realize the importance of protecting the unsuspecting child that this large group of fatalities may be reduced. An aroused public has made In-dependence Day devoid of much of its former sor-row. Education of the parent can make the home a safer place for the child.

## The Honorary Consultants of the Army Medical Library

In the April 1945 issue of the *Bulletin of the Medi-cal Library Association* full details are given con-cerning the newly appointed Association of Honor-ary Consultants to the Army Medical Library which has been formed to aid the Surgeon General in formulating plans for the future of our great national Library. All associated with the medical profession of this country will look for wise leadership to the Consultants who will be expected to secure the best advice available in this country concerning problems of library administration. Surgeon General Kirk, in appointing the Consultants, indicated that their first responsibility would be to aid him in drawing plans for the erection of the long needed new building to house the Library. On three occasions during the past fifteen years the War Department and Congress have been asked for an appropriation to build an

appropriate home for the Army Medical Library but for various reasons, largely arising from peace time budgetary restrictions of the War Department, no action was taken. With the outbreak of war the vast importance of the Army Medical Library became apparent, and despite shortages both of personnel, cataloguing facilities, and of the actual books themselves (in several annual budgets since 1930 no funds whatsoever were appropriated for the purchase of new books), the Library has served the medical profession with marked effectiveness. Through their microfilm service thousands of papers in journals have been sent to fighting fronts in every quarter of the globe; and laboratories engaged in war research have similarly benefited by the expeditious microfilm service in the Library.

Colonel Harold W. Jones, the Director of the Army Medical Library, realizing that the Library had "coasted" on its own momentum since the last war, that much of their material remained uncatalogued, and that owing to haphazard classification many important books could not be found on the shelves, induced the Surgeon General's Office to request funds from the Rockefeller Foundation for a survey of the problems of the Library. Under the effective chairmanship of Dr. Keyes D. Metcalf, Librarian at Harvard University, a thorough-going study was made and it was recommended that the entire library should be recatalogued in accordance with modern methods, that a new scheme of classification should be developed within the framework of the Library of Congress schedules, and that appropriations be recommended for a new building on Capitol Hill so that the new Army Medical Library would be closely articulated with the Library of Congress.*

Mr. MacLeish enthusiastically favored the latter proposal and authorized the Library of Congress to modify their own classification schedules to conform with those to be adopted by the Army Medical Library—all this with the possibility in view that the bulk of L.C.'s medical holdings would utimately be transferred to the Army Medical Library if and when the new building were erected and sound, budgetary provision had been made for the Army Medical Library by the Congress or the War Department. It is hoped that when the new classification of the Army Medical Library is available medical libraries throughout the country will feel disposed to adopt it since it will bring them into close liaison with the principal medical library in the country and it will also have the further advantage of making available to them catalogue cards issued through L.C. which in each instance will have the classification indicated.

The Honorary Consultants thus have a heavy responsibility in guiding the future developments of the Army Medical Library. They have wisely incorporated themselves and appointed an Executive Committee for the conduct of interim business. They have also appointed several standing committees to advise on special problems: *e.g.*, Building, Acquisitions, Rare Books, and Endowments and Grants. The membership of the Executive Committee is as follows: Dr. Clyde L. Cummer, Dr. Wilburt C. Davison, Dr. Morris Fishbein, Dr. Henry R. Viets, and the officers of the Association (Dr. John F. Fulton, *president and chairman of the Committee;* Dr. Chauncey D. Leake, *vice-president;* Colonel Harold W. Jones, *secretary-treasurer).*

Further details concerning the first annual meeting of the Honorary Consultants held last October will be found in the April number of the *Bulletin of the Medical Library Association;* also the constitution and by-laws.

## Yale Medical Library Exhibit On the History of Infection

During April and the first two weeks in May the Yale Medical Library has placed on display an unusual collection of books illustrating the history of epidemic infections and the recognition of the causal agent of contagious disease. The concept of "contagium vivum," although implicit in Hippocrates' famous book on Epidemics, was not clearly crystallized until the 16th century when Girolamo Fracastoro, the Italian physician and poet, published his *De contagione.* The rare original edition (1546) is shown in the exhibit together with the recent English translation by Wilmer Cave Wright. The original edition of the *De peste* by the Roman Catholic priest, Athanasius Kircher (Rome 1658), is also exhibited. Kircher believed that plague was spread by tiny invisible "worms," and that human beings passed them from one to another by direct contact.

During the 17th and 18th centuries the idea of a living contagion was further crystallized and an

*Metcalf, K. D.: The National medical library; report of a survey of the Army medical library, financed by the Rockefeller foundation and made under the auspices of the American library association, by K. D. Metcalf, Janet Doe, T. P. Fleming [and others]. Chicago, 1944.

attempt was made to distinguish specific contagions in order to account for different types of epidemic. In the library of the late Dr. Harvey Cushing there was an unusual collection of the plague tracts issued in London during the plague year of 1665. They are shown together with George Thomson's book describing autopsy findings on victims of the plague, this last being one of the Historical Library's most recent acquisitions. The Library is also forunate in having the first edition of John Fothergill's *Account of the sore throat* (London 1748)—the original description of diphtheria. Of special interest to Connecticut physicians is the little known tract of Thaddeus Clark, published in Norwich in 1795, entitled *A treatise on the scarlatina anginosa.* This is one of the earliest descriptions in this country of epidemic scarlet fever.

Perhaps the most interesting part of the exhibit is contained in two cases dealing with the history of puerperal fever. The original edition of Alexander Gordon's monograph on epidemic puerperal fever, published at Aberdeen in 1795, is shown (on loan from the Academy of Medicine of Northern New Jersey). Dr. Herbert Thoms has written of Gordon: "Not only did he discover a great surgical principle, but with true courage he proclaimed it in the face of opposition amounting to persecution. . . . I heartily agree with the writer who says, 'To Gordon of Aberdeen must be ascribed the credit of having first clearly demonstrated the infective nature of puerperal fever'." Charles White's *Treatise on lying-in women* is also represented, together with the original tracts of Oliver Wendell Holmes and Ignaz Semmelweis on puerperal fever.

All physicians in the State who may be interested are cordially invited to visit the Library and inspect the exhibit.

## Internship Appointments

A program for control of internship placement has been formulated by the Council of the Association of American Medical Colleges and has been approved by representatives of the American Hospital Association, Catholic Hospital Association, American Protestant Hospital Association and American Medical Association.

Medical colleges and hospitals have been increasingly concerned over the excessive competition in the recruitment of medical students for internships. This development has resulted from the depletion of the supply of house officers by military demands, and it has reached the point where appointments of internships during the second year in medical school have not been uncommon.

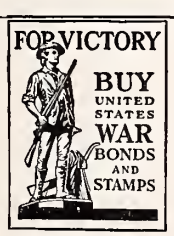
The correction of the situation requires the cooperation of the medical schools and the hospitals in carrying out the principles of the new agreement. This program provides that information regarding student records, in support of applications for internship appointment, is not to be released until the end of the junior academic year. This restriction includes the sending of letters of recommendation and summaries of scholastic records by medical college deans and faculty members. Under the plan hospitals are asked not to make appointments to internships until recommendations and credentials covering the first three years of medical school work have been received.

This new program cannot be expected to work perfectly but it will provide a basis for the gradual development of an orderly, systematic method of appointment to internships.

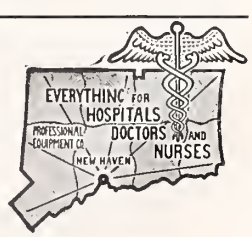
## Notice

**Before you consign your copies of the JOURNAL to the waste paper collection, please offer them to the wife of some physician in the armed forces. There have been many requests for copies by these wives at home.**

The Editor




YOURS FOR THE BASKING — Our complete rental service includes various types of sun lamps available to your patients on prescription. Everyone who needs the tonic benefits of ultra-violet these busy "all out" days, cannot spare the time to bask on the beach, but details on PROFESSIONAL summer sun for everyone, for convenient bedroom use, is yours for the asking. Professional Equipment Co., New Haven.




(SEE PAGE 2)

## CALL

## ANNUAL MEETING HOUSE OF DELEGATES

The 1945 Annual Meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Wednesday, May 23, commencing at 10:30 o'clock in the morning.

Members of the House will be guests of the Society at luncheon at 1:00 o'clock.

H. Gildersleeve Jarvis, President
Creighton Barker, Secretary

Chairmen of Committees not members of the House of Delegates are invited to attend this meeting to present and discuss the reports of their committees.

## NOMINATIONS FOR OFFICERS AND COMMITTEES 1945 - 1946

The Council, serving as the nominating committee for the Society in compliance with Chapter VII, Section 3 of the By-Laws of the Society, presents the following nominations for officers and committees for the year 1945-1946.

Nominations marked with an asterisk are renominations.

| | |
|---|---|
| A President-Elect | Cole B. Gibson |
| A First Vice-President | Arthur H. Jackson |
| A Second Vice-President | Louis P. Hastings |
| A Treasurer | *Hugh B. Campbell |
| An Executive Secretary | *Creighton Barker |
| An Editor of the JOURNAL | *Stanley B. Weld |
| A Delegate and an alternate to the American Medical Association for the term July 1, 1945, to June 30, 1947 | *Thomas P. Murdock<br>*Francis G. Blake |

PROGRAM COMMITTEE—one member for a term of three years to succeed H. M. Marvin—Samuel C. Harvey. One member to serve the unexpired term of John C. Leonard, resigned—H. M. Marvin

so that the committee will consist of:

H. M. Marvin, New Haven, *Chairman*
William H. Resnik, Stamford
Samuel C. Harvey, New Haven

Associate Member: John F. Fulton, New Haven

JOURNAL EDITORIAL BOARD—one member for a term of four years

*Herbert Thoms, New Haven

so that the Board will consist of:

1942 Paul P. Swett, Hartford
1943 Oliver L. Stringfield, Stamford
1944 Frank S. Jones, Hartford
1945 Herbert Thoms, New Haven

Associate Member: Harold S. Burr, New Haven

CLINICAL CONGRESS COMMITTEE—for the term October 1, 1945 to September 30, 1946

*Francis G. Blake, Chairman
*Herbert Thoms, Secretary
*Charles E. Sanford, Treasurer
President of the Society
Chairman of the Council
Executive Secretary
Editor of the JOURNAL
Eight Secretaries of Component County Medical Associations
Such other members as the committee shall appoint

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County, Louis P. Hastings, Hartford
*Litchfield County, Sanford H. Wadham, Torrington
*Middlesex County, Harry S. Frank, Middletown
*New Haven County, Charles T. Flynn, New Haven
*New London County, Edmund L. Douglass, Groton
*Tolland County, Donald M. Beckwith, Rockville
*Windham County, Andrew O. Laakso, Danielson
President of the Society
Executive Secretary of the Society
Committee on National Legislation

COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION—The Connecticut Medical Examining Board—one member for five years

George M. Smith, New Haven

so that the board will consist of:

1941 John C. Rowley, Hartford
1942 Charles J. Bartlett, New Haven
1943 Thomas P. Murdock, Meriden
1944 Daniel C. Patterson, Bridgeport
1945 George M. Smith, New Haven

COMMITTEE ON HONORARY MEMBERS AND DEGREES—one member for a term of three years

H. Gildersleeve Jarvis, Hartford

so that the committee will consist of:

1943 Roy L. Leak, West Hartford
1944 George M. Smith, New Haven
1945 H. Gildersleeve Jarvis, Hartford

COMMITTEE ON NATIONAL LEGISLATION

*James R. Miller
*Thomas P. Murdock
*Creighton Barker
Chairman, Committee on Public Relations
Chairman, Committee on Public Policy and Legislation

COMMITTEE ON HOSPITALS—two members for a term of three years

Louis P. Hastings, Hartford
Robert R. Nesbit, New Haven

so that the committee will consist of:

1943 Thomas H. Russell, New Haven
1943 James Douglas Gold, Bridgeport
1944 Harold W. Wellington, New London
1944 John P. Hanley, Stafford Springs
1945 Louis P. Hastings, Hartford, *Chairman*
Robert R. Nesbit, New Haven

COMMITTEE ON PUBLIC HEALTH

*Howard S. Colwell, New Haven, *Chairman*
*Donald A. Bristoll, New Britain
*Jessie W. Fisher, Middletown
*Albert C. Freeman, Norwich
*Joseph H. Howard, Bridgeport
*Joseph I. Linde, New Haven
*Luther K. Musselman, New Haven
*Mario L. Palmieri, Middletown
*Karl T. Phillips, Putnam
*J. Harold Root, Waterbury
*Howard G. Stevens, New Milford
*Maurice J. Strauss, New Haven
*Oliver L. Stringfield, Stamford
*Carl L. Thenebe, West Hartford

Associate Member: Friend L. Mickle, Hartford

COMMITTEE ON TUMOR STUDY

*Hugh M. Wilson, New Haven, *Chairman*
Irving B. Akerson, Bridgeport
John D. Booth, Danbury
Donald A. Bristoll, New Britain
George P. Cheney, New London
Joseph O. Collins, Waterbury
*A. Nowell Creadick, New Haven
*Thomas J. Danaher, Torrington
*Edward W. Foster, Meriden
*Carl C. Harvey, Middletown
*Thomas S. Harvey, Meriden
*Louis P. Hastings, Hartford
Joseph H. Howard, Bridgeport
Russell A. Keddy, Stamford
*Ralph E. Kendall, Hartford
*Kenneth K. Kinney, Willimantic
Michael J. Lawlor, Waterbury
Edwin A. Lawrence, New Haven
John A. McCreery, Greenwich
*William Mendelsohn, New Haven
Robert R. Nesbit, New Haven
Lincoln Opper, Norwich
*Berkley M. Parmelee, Bridgeport
Karl T. Phillips, Putnam
*Douglas J. Roberts, Hartford
Herbert Thoms, New Haven
State Commissioner of Health

Associate Member: William C. Welling, Hartford

COMMITTEE ON PUBLIC RELATIONS

*C. Charles Burlingame, Hartford, *Chairman*
Howard S. Colwell, New Haven
C. Frederick Yeager, Bridgeport
Thomas J. Danaher, Torrington
*Mario L. Palmieri, Middletown
George H. Gildersleeve, Norwich
*Donald M. Beckwith, Rockville
*William M. Shepard, Putnam

Associate Member: Howard W. Haggard, New Haven

Committee on Industrial Health

*C. Frederick Yeager, Bridgeport, *Chairman*
*James H. Biram, Hartford
Walter M. Brunet, Bridgeport
*Gerard M. Chartier, Danielson
Bernard S. Dignam, Thompsonville
*John N. Gallivan, East Hartford
*Albert S. Gray, Hartford
*Martin I. Hall, Bristol
Richard J. Hinchey, Waterbury
*Andrew J. Jackson, Waterbury
*Robert W. Kaschub, Groton
John F. Kilgus, Litchfield
*Robert P. Knapp, Manchester
*Arthur B. Landry, Hartford
*Eugene F. Meschter, Stamford
*Philip J. Moorad, New Britain
*Frank T. Oberg, Bridgeport
Israel S. Otis, Meriden
*John R. Paul, New Haven
*Crit Pharris, East Hartford
*C. John Satti, New London
*Paul W. Vestal, New Haven
*Ellwood Weise, Bridgeport

Delegates to State Societies for Term of One Year—July 1, 1945 to June 30, 1946

To Maine:
*Stanley B. Weld, Hartford
*Orville F. Rogers, New Haven

To Massachusetts:
*G. Gardiner Russell, Hartford
Clifford D. Moore, Newtown

To New Hampshire:
*Clyde L. Deming, New Haven
*George H. Gildersleeve, Norwich

To New Jersey:
J. Harold Root, Waterbury
*Oliver L. Stringfield, Stamford

To New York:
Joseph H. Howard, Bridgeport
*H. Gildersleeve Jarvis, Hartford

To Rhode Island:
Charles G. Barnum, Groton
*Arthur B. Landry, Hartford

To Vermont:
*George A. Gosselin, Hartford
*Roy L. Leak, West Hartford

To Special Societies

To Connecticut Hospital Association:
Louis P. Hastings, Hartford

To Connecticut Pharmaceutical Association:
William T. Salter, New Haven

## Committees Appointed 1945 - 1946

In accordance with provision of the By-Laws and actions of the House of Delegates at various times, the Council has appointed the following committees for the year 1945-1946.

Committee on Permanent Funds

*Charles T. LaMoure, Windham Center
*Floyd A. Weed, Torrington
Treasurer of the Society

Committee on Cooperation With the Yale School of Medicine

Chairman of the Council
President of the Connecticut Medical Examining Board
Chairman of the Committee on Public Policy and Legislation
*Charles T. Flynn, New Haven
*W. Bradford Walker, Cornwall

Conference Committee With Connecticut Pharmaceutical Association

*Stanley B. Weld, Hartford, *Chairman*
*William J. H. Fischer, Milford
*John H. Foster, Waterbury
*Barnett Greenhouse, New Haven
William T. Salter, New Haven

Committee on Narcotic Drug Addiction

*John H. Foster, Waterbury, *Chairman*
*C. Charles Burlingame, Hartford
*A. Bliss Dayton, New Haven
*Alfred Labensky, New London
*Chester Waterman, Portland
Associate Member: Howard W. Haggard, New Haven

Board of Trustees of the Building Fund—one member to serve a term of five years

*Roy L. Leak, West Hartford

so that the Board will consist of

1946 Daniel Sullivan, New London
1947 C. Charles Burlingame, Hartford
1948 James Douglas Gold, Bridgeport, *Chairman*
1949 George M. Smith, New Haven
1950 Roy L. Leak, West Hartford

Committee on Prepaid Medical Service

*J. Harold Root, Waterbury, *Chairman*
*George M. Craig, Middletown
*Richard E. Dunne, Hartford
*H. M. Marvin, New Haven
*James R. Miller, Hartford
*Thomas P. Murdock, Meriden
*Berkley M. Parmelee, Bridgeport
*Herbert Thoms, New Haven
*William H. Weidman, Norwich
*Stanley B. Weld, Hartford

Advisory Committee to Woman's Auxiliary

*Ralph L. Gilman, Storrs, *Chairman*
*John D. Booth, Danbury
*Martha L. Clifford, Hartford
*Jessie W. Fisher, Middletown
*Cole B. Gibson, Meriden
*Alfred Labensky, New London
*E. Myles Standish, Hartford

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 Church Street New Haven

## ANNUAL REPORT OF THE SECRETARY

### Membership

FAIRFIELD COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 466 |
| New Members | | 23 |
| | | 489 |
| Died | 6 | |
| Lost by resignation, transfer, dropped non-payment | 11 | 17 |
| Membership April 1, 1945 | | 472 |

HARTFORD COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 591 |
| New Members | | 20 |
| | | 611 |
| Died | 8 | |
| Lost by resignation, transfer, dropped non-payment | 1 | 9 |
| Membership April 1, 1945 | | 602 |

LITCHFIELD COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 79 |
| New Members | | 1 |
| | | 80 |
| Died | 3 | |
| Lost by resignation, transfer, dropped non-payment | 0 | 3 |
| Membership April 1, 1945 | | 77 |

MIDDLESEX COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 76 |
| New Members | | 4 |
| | | 80 |
| Died | 0 | |
| Lost by resignation, transfer, dropped non-payment | 2 | 2 |
| Membership April 1, 1945 | | 78 |

NEW HAVEN COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 608 |
| New Members | | 37 |
| | | 645 |
| Died | 12 | |
| Lost by resignation, transfer, dropped non-payment | 10 | 22 |
| Membership April 1, 1945 | | 623 |

NEW LONDON COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 (corrected) | | 130 |
| New Members | | 5 |
| | | 135 |
| Died | 3 | |
| Lost by resignation, transfer, dropped non-payment | 2 | 5 |
| Membership April 1, 1945 | | 130 |

TOLLAND COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 | | 19 |
| New Members | | 0 |
| | | 19 |
| Died | 0 | |
| Lost by resignation, transfer, dropped non-payment | 0 | 0 |
| Membership April 1, 1945 | | 19 |

WINDHAM COUNTY

| | | |
|---|---|---|
| Membership April 1, 1944 | | 39 |
| New Members | | 1 |
| | | 40 |
| Died | 0 | |
| Lost by resignation, transfer, dropped non-payment | 0 | 0 |
| Membership April 1, 1945 | | 40 |

TOTALS

| | |
|---|---|
| Fairfield | 472 |
| Hartford | 602 |
| Litchfield | 77 |
| Middlesex | 78 |

| | |
|---|---|
| New Haven | 623 |
| New London | 130 |
| Tolland | 19 |
| Windham | 40 |
| Total | 2,041 |
| Associate Members | 9 |
| | 2,050 |
| Net gain for year | 33 |

## Members of The Connecticut State Medical Society Returned to Civilian Status From Military Service

FAIRFIELD COUNTY

Beck, Eugene C., South Norwalk (N)
Buckley, John W., Bridgeport (USPH)
Connors, Edwin A., Bridgeport (A)
Ellrich, David, Westport (A)
Knepp, James W., Bridgeport (A)
Mathews, Frank P., Southport (N)
Moore, Clifford D., Newtown (USPH)
Unger, Milton, Bridgeport (N)
Ward, James P., Bridgeport (N)

HARTFORD COUNTY

Clancy, John J., Hartford (N)
Glass, William H., Hartford (USPH)
Hall, Wendell C., Hartford (A)
Hennessey, James J., Hartford (N)
Johnson, Paul R., Hartford (USPH)
Lewis, Smauel D., Elmwood (A)
Tombari, Seraphino P., Waterford (A)
LoVetere, Angelo A., New Britain (A)
Padula, Vincent C., Hartford (A)
Schaeffer, Jacob, Glastonbury (A)
Shull, John C., West Hartford (N)
Stevenson, William R., Bristol (A)
Tirella, Fred F., Bristol (N)

LITCHFIELD COUNTY

Kott, Joseph A., Torrington (A)

MIDDLESEX COUNTY

Gissler, Norman E., Middletown (N)
Joyce, William M., Middletown (A)

NEW HAVEN COUNTY

Appell, Harold S., West Haven (N)
Boyarsky, Harry M., Wallingford (A)
Bruckner, William J., New Haven (A)
Chasnoff, John A., West Haven (A)
Corradino, Charles L., New Haven (A)
Fiorito, Joseph A., New Haven (A)
Goodrich, William A., Waterbury (A)
Jennes, Sidney W., Waterbury (A)
Lirot, Stephen, Meriden (N)
McDonnell, Ralph E., New Haven (USPH)
Sperandeo, Anthony, New Haven (A)
Stetson, Charles, Milford (A)

NEW LONDON

Rapp, Albert G., New London (A)
Savage, Philip J., New London (A)

## April Council Meeting

The monthly meeting of the Council was held at the State office on April 6, 1945. There were present: James R. Miller, H. Gildersleeve Jarvis, Joseph H. Howard, Hugh B. Campbell, Thomas P. Murdock, Arthur B. Landry, Floyd A. Weed, Charles Russman, Herbert Thoms, George H. Gildersleeve, Charles T. LaMoure, Robert C. Paine and Creighton Barker. Absent were Samuel F. Mullins and Stanley Weld.

## Service Bureau For Returned Medical Officers

The Council authorized the Secretary to proceed with the development of a Service Bureau for medical officers returning to Connecticut after discharge. This Bureau will provide services and advice in connection with relocation in practice, extension of education, refresher courses and serve as liaison between the returning physician and the Veterans Administration whenever necessary. A memorandum on this subject has been prepared by the Secretary and has the approval of the Council. When further details have been developed it is proposed that an announcement of the Bureau will be sent to all members of the Society now in military service.

## Conference On Radiology

After an unavoidable delay the Council has conferred with the Board of Trustees of the Connecticut Hospital Association on the subject of the practice of radiology in hospitals. A joint meeting was held on April 20 and a report of the proceedings of the conference will be published at a later date.

## Student Members

One hundred and sixty-seven applications have been received from medical students from Connecticut seeking election as student members of the Society. This group was all elected by the Council and it is the first time that student members are included as special members of the Society.

## Recommended for Licensure

The Connecticut Medical Examining Board has announced that during its regular March examina-

tions just concluded twenty-nine candidates were recommended for licensure to practice medicine in Connecticut. They were as follows:

Harold C. Anderson, New Haven Hospital, New Haven
Ralph W. Ballin, Uncas-on-Thames, Norwich
John H. Bliss, Lakeville
Jessie Reed Cockrill, 329 East Main Street, Bridgeport
James A. F. Delevett, New York City
Wallace C. Douglass, New Rochelle, New York
Frank G. Elliott, 20 Pliny Street, Hartford
Arnold R. Friesen, Meriden Hospital, Meriden
Dwight Griswold, Old Lyme
Riley H. Guthrie, Norwich State Hospital, Norwich
Simon Kove, Bronx, New York
Bertrand E. Lowenstein, 333 Cedar Street, New Haven
Anna Lublin, 39 Kent Street, Hartford
Michael C. Luciano, 349 Beechmont Avenue, Bridgeport
John F. Marchand, 333 Cedar Street, New Haven
Sawyer E. Medbury, Putnam
Cornelius Mezey, Lawrence & Memorial Hospital, New London
Gail F. Moxon, Mansfield State Training School and Hospital, Mansfield Depot
Nelson K. Ordway, 310 Cedar Street, New Haven
Marshall C. Pease, Branchville Road, Ridgefield
Albert I. Robbins, Roxbury, Massachusetts
Fred Rosner, 816 Fairfield Avenue, Bridgeport
Joseph W. Saidel, Hartford Muncipal Hospital, Hartford
Arthur W. Seligmann, Larchmont, New York
Charles T. Snyder, 14 Ocean Drive North, Stamford
Susan B. Spencer, Boston Post Road, Madison
Herbert T. Wagner, 24 Orange Street, Meriden
Mario H. Yannello, New Britain General Hospital, New Britain
U. Joyce Yerwood, 45 Richmond Drive, Old Greenwich

## Dues Exemption For Discharged Medical Officers

Dr. Gildersleeve, the Councilor from New London County, presented a resolution from the New London County Medical Association asking the Council to reconsider the subject of dues exemption for members returning from military service. At present a resolution passed by the House of Delegates on December 12, 1940, applies and that resolution requires that members returning from military service commence payment of dues to the Society, on a pro rated basis, as of the first of the month following their return to civilian practice. The Council will consider a resolution extending the period of exemption for presentation to the House of Delegates on May 23, 1945.

## Medical Artists Exhibit

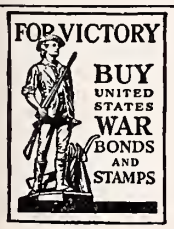
A medical art exhibit of national scope will be opened at the Yale Medical Library on May 20 and will continue until June 2. This display, which is sponsored by Modern Medicine, includes work by twenty-six leading medical artists from medical schools and clinics in this country. In addition, examples of the work of the late Max Brödel will be shown Mr. Brödel was the founder of the Department of Art as Applied to Medicine at the Johns Hopkins Hospital. The exhibit includes about one hundred illustrations and the exhibitors include such well known names as Tom Jones, Mildred Codding, W. C. Shepard, Elizabeth Brödel, Russell Drake, Ralph Sweet and Armin Hemberger. The last named is the medical artist associated with the Yale School of Medicine. The exhibit is open to all interested.

FOR USE IN THE TREATMENT OF ULCERS AND BURNS

| | |
|---|---|
| Oxyquinoline Sulfate | 10 grains |
| Chlorobutanol | 40 grains |
| Liquid Petrolatum | ½ dram |
| Ointment of Scarlet Red | 4 oz. |

Approximate price to patient: 120 grams for $1.75.

References: The Merck Manual, 7th Edition, page 214. In use at the Middlesex Hospital, Middletown, Conn.




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# H.B. 601 — COMPULSORY SICKNESS INSURANCE
## A Report on the Public Hearing to the Editor

JAMES RAGLAN MILLER, M.D., *Hartford*

YOU HAVE suggested that the readers of the JOURNAL might be interested in an account of the hearing before the Committee on Insurance which considered H.B. 601 on Compulsory Sickness Insurance. I am glad to make this report for I too feel that the members of the Society would like to know a little more about what happened and about the tone of the discussion than was given in the daily press, although it is fair to say that there was no distortion in the reporting which was carried in the newspapers.

Dr. Barker was unavoidably absent from the hearing which in itself added to the sense of responsibility that I felt in undertaking to represent the medical profession's attitude on this great issue. I was comforted, however, in the thought that the difficulties are much less if one adheres to the principle that organized medicine is interested in the health and welfare of the people as members of a profession dedicated to service and not as a business or labor group whose sole interest is in the protection of the rights and privileges of its members.

Several speakers opposed the bill from the point of view of business and of the taxpayer and in so doing called attention to the experience of the Rhode Island Sickness Law which had been operating at a loss of several hundred thousand dollars in the past year.

Opposed to the bill also was a representative of the Christian Science Church who in a lengthy prepared statement claimed injustice for members of his faith who would be taxed and regimented contrary to their beliefs and way of life.

Speaking in favor of the bill was Miss Margaret Connors, executive secretary of the Committee on Industrial Organization. It was apparent from her warm advocacy of the bill and her intimate knowledge of it that the organization which she represented was responsible for its introduction. One of the committee members asked her why the bill called for contributions only from the State and from employers but none from labor and she admitted that perhaps it would be well if laborers also made their contribution. No one was willing to guess how much the bill would cost the State though it is possible to make a rough estimate at one per cent payroll deduction. Granting that the payroll would remain approximately stationary, it would come to something in the neighborhood of 15 or 16 million dollars.

Lieutenant Governor Snow appeared in favor of the bill as a champion of the great middle group in society who cannot, like the wealthy, meet the expenses of illness and who refuse to accept a charity which makes medical and hospital care available to the poor. Professor Snow, perhaps as a lifelong teacher, could see no reason why public medicine could not be provided in the same manner and just as effectively as public education and he indicated that we could learn much from Russia in the matter of provision of medical care.

In presenting the attitude of the Connecticut State Medical Society I was at pains immediately to establish the character of our interest by repeating the offer which had been made on behalf of the Society four years previously at the hearings on the socalled Epstein Bill. At that time the resources of the Society were offered to any agency of the State to assist in providing more and better medical care to the people of the State and particularly to assist in the drafting of any legislation for that purpose. In this cooperative spirit, therefore, I argued that S.B. 601 would be ineffective. Since it is optional with the physician whether he serves under the plan or not I expressed the doubt that Connecticut physicians would join such a program. Under these circumstances it would be necessary to import physicians from outside of the State.

One of the proponents of the bill had referred in glowing terms to Beveridge's "cradle-to-the-grave" plan and it seemed only fair to call the attention of the Committee to a statement made by Sir William Beveridge in his latest book, "Full Employment in a Free Society." In paragraph 214 he writes: "Maintenance of health does not depend solely or primarily on health services, and still less on medical treatment. It depends even more on good food; on sufficiency of the other necessaries of life; on healthy

homes . . ." and in a later paragraph he writes: "Whether the medical profession is organized in part or in whole as a public service, there is room and need for a great increase of hospitals and institutions of all kinds."

I pointed out that Beveridge was speaking about Great Britain but that these words applied in large measure also to this country and I reminded that the Connecticut State Medical Society appears before legislative committees on numerous occasions advocating extension of health services by the State. I called the Committee's attention to a statement made by Nathan and Sinai in their comprehensive book on Sickness Insurance to the effect that no sickness insurance legislation has ever been proposed as a health measure but as a means of dealing with poverty in sickness. The difference between these two motives is real. The latter objective is typified in the Rhode Island Cash Sickness Law and when questioned if the State Medical Society would favor this type of sick benefit legislation, I stated that we should prefer to reserve judgment until it became evident that the measure was being worked out better than it appeared at present. (It might have been observed, of course, that physicians could scarcely object if their patients receive cash sickness benefits from any source though it must be remembered that in this world one seldom gets something for nothing and under such arrangements the physician is under the obligation to certify as to the length of disability on which benefits are determined. If, then, the physician, his patient and the fund representatives have conflicting ideas, there is room for discontent.)

It was inevitable that any speaker on the general subject of sickness insurance should be asked the "64 dollar question" and at this hearing it took the following form raised by a member of the Committee. "Doctor, do you not believe that socialized medicine will eventually be established?" The hearing would have been incomplete without this question. In reply I pointed out that the achievements of completely socialized medicine such as we see in the armed services depend on two factors: first, that the patients are carefully selected risks and second, that they as well as the physicians are thoroughly regimented. To this a third reason could have been added, namely, that patriotism during war evoked on the part of all those engaged in medical care a response of top quality effort. In peace times this is conspicuous by its absence as is demonstrated in the Veterans Administration.

In closing I added that when and if all society is socialized, physicians along with the rest will be regimented and will probably be as happy as any for they are habituated to medical care as a service to their fellow men.

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## No Solution of the Radiology Problem

The Commission on Hospital Standards held a conference at Chicago in February on "Radiology in Prepayment Plans." On the program appeared the president of the American College of Radiology who is also the president of the California Medical Association, the director of the Hospital Service Plan Commission of The American Hospital Association, the chairman of the A. M. A. Council on Medical Service and Public Relations, and the director of the Chicago Plan for Hospital Care. It was hoped that the discussions would lead to a compromise solution ending the long controversy over the inclusion of radiology among Blue Cross benefits and thus permit radiologists all over the country to give their full support to the Blue Cross movement. Unfortunately, no such solution was forthcoming.

The American College of Radiology through its representatives emphasized the following principles:

1. Blue Cross plans were organized to furnish hospital service to insured individuals. As such, they help to eliminate the unpredictable burden of hospital expense, and deserve the enthusiastic support of all physicians. This support will not be forthcoming so long as some Blue Cross plans furnish certain medical services as a part of hospital care which hospitals guarantee to furnish for an inclusive per diem from the hospital service corporation.

2. Most of the objections to the inclusion of radiology among Blue Cross benefits would be answered if Blue Cross plans would pay separate cash benefits for these medical services. Thus hospitals would be paid for strictly hospital services and would not be required to meet the cost of certain medical services from the per diem received from the service plan. (The Blue Cross plans in Washington, Iowa, and Florida have adopted this method.) Preferably, such benefits should be paid to the patient-subscriber.

3. A better method would be to establish medical or surgical care plans under medical society control in all communities, and to shift all medical benefits from Blue Cross to the Blue Shield, or medical care plan, where they belong.

# MEDICINE AND THE WAR

## Selective Service System Connecticut State Headquarters Selective Service Regulations For Deferred Classification

Selective Service now requires every male physician, between the ages of 18 and 37 inclusive, to personally complete and submit, or have submitted for him by his employer, an "Affidavit for Occupational Classification" to the Procurement and Assignment Service for Physicians for certification and transmittal to the Local Board having jurisdiction over the registrant.

The forms to be used by various age groups, the number of forms to be submitted, and where these forms may be obtained are listed below:

1. DSS Form 42-A (Special-Revised) for all male physicians 18 to 29 inclusive; two (2) triplicate copies of this form, obtainable from the Procurement and Assignment Service for Physicians, 258 Church Street, New Haven, Connecticut. This procedure includes those physicians in this age group who have been previously physically disqualified for appointment as medical officers in the Army or Navy and physicians who are classified as essential because of their civilian activities.

2. DSS Form 42 for all male physicians 30 to 37 years of age inclusive; one original and two copies. This form is obtainable from Local Boards.

(a) DSS Form 42 will be used by all physicians between the ages of 30 and 37 years of age inclusive, who have been previously physically disqualified for appointment as medical officers in the Army or Navy and physicians who are classified as essential because of their civilian activities. A physician who has been disqualified for military service must support with evidence the fact that he has been disqualified and by what agency.

Deferred classifications are established for a period not to exceed six months. It is the personal responsibility of each physician to submit "Affidavits for Occupational Classification" shortly before the expiration of each current deferred classification.

All II-A or II-B classifications of physicians between the ages of 18 through 37 will be reopened by Local Boards, and no deferred classification will be continued, or established, without an affidavit, certified by the Procurement and Assignment Service, being in the hands of the Local Board at the time of consideration for deferred classification.

If the Procurement and Assignment Service certifies an affidavit, the affidavit will be forwarded to the Local Board and a copy sent to State Selective Service Headquarters.

If the Procurement and Assignment Service does NOT certify to the essentiality of the physician, these forms will be returned to the physician who submits them. The physician may then submit the forms returned to the Local Board. No physician 18 to 37 years of age inclusive will be considered essential and eligible for deferred classification unless his forms are certified by the Procurement and Assignment Service and submitted by the Chairman to the Local Board.

These procedures are not necessary for the following, although these physicians should notify the State Chairman of the Procurement and Assignment Service of their status.

1. Physicians who are classified by Selective Service as IV-F or II-A(F).

2. Physicians who are commissioned officers in the Medical Corps of the Army or Navy and whose orders to duty are deferred under the 9-9-9 Program.

3. Physicians who are classified by Selective Service as I-C Disc.

## Colonel Hiscock Receives Legion of Merit

Colonel Ira V. Hiscock, in charge of the public health section of the Army's civil affairs division, has received the Legion of Merit for his work in typhus control in liberated countries, especially Italy. On April 12 Colonel Hiscock was placed on inactive status to become chairman of Yale University's department of public health. He was a member of the Yale faculty before entering the Army.

## Lieutenant Murray Killed On Iwo Jima



The Hartford Hospital suffered the second casualty from among its recent interns when Lieutenant Kenneth J. Murray MC-USNR, was killed during the invasion of Iwo Jima. Ken Murray was a native of Boston, Massachusetts, and graduated from Boston College in 1937. He received his M.D. degree at Jefferson Medical College in 1941. Following this he served an internship at Hartford Hospital receiving a commission as Lieutenant (j.g.) in July 1943 and assigned in turn to Boston, Camp LeJeune, North Carolina, and Camp Pendleton, San Diego, California.

For a year before his death Lieutenant Murray was on active duty in the Pacific. In February 1944 he participated in the invasion of the Marshall Islands, in June that same year in the Saipan invasion, and in the following month in the Tinian invasion. In October 1944 he was made battalion surgeon. For his heroism on Saipan he received the Bronze Star and the Presidential citation.

Ken Murray was one of the first surgeons to fall on Iwo Jima. His body was buried at sea with full military honors. Surviving him are his mother, his wife, Winifred Pollard, Hartford Hospital Nursing School, and an infant daughter. Those who knew Ken Murray will honor his memory. He was the true hero.

## Colonel Canfield Awarded Bronze Star Medal

Col. Norton Canfield of Leetes Island, Stony Creek, was recently presented with the Bronze Star Medal for meritorious service. He is senior consultant in otolaryngology, in the office of the chief surgeon at a base overseas.

Colonel Canfield entered the service December 1, 1942, being commissioned lieutenant colonel in the Medical Corps with assignment as special consultant in the European theater. He was promoted to colonel in December, 1944. He is a graduate of Dartmouth and the University of Michigan, coming to Yale in 1933, as instructor in otolaryngology. Colonel Canfield is on leave of absence from the Yale School of Medicine, and also as associate surgeon, New Haven Hospital.

On October 30, 1944 Colonel Canfield was married to Pandita Clark of Gloucestershire, England. This is the first marriage to be reported among Connecticut medical officers.

## General Bayne-Jones Emphasizes Importance of Research on National Scale

"Experience of the past and vision of the future clearly show the need for organization, coordination and support of medical research, as of all scientific research, on a national scale," said Brigadier General Stanhope Bayne-Jones, USA, Deputy Chief of the Preventive Medicine Service, Office of The Surgeon General, in a recent address at the semicentennial celebration of the Yale Chapter of Sigma Xi at New Haven.

Citing control of the typhus fever epidemic at Naples through the use of DDT, General Bayne-Jones stated that "the synthesis of a half a dozen sciences is in a single puff of DDT powder."

He said that planning is now being made for post war research but "when the compelling necessities of the war end and the urge of patriotism diminishes, there probably will not be the same degree of motivation toward group work for the solution of scientific problems."

He added that funds and laboratories may be made available but stressed the need to arouse or keep at high pitch in post war years the present spirit of collaboration and intense application.

## Gliders Carry Wounded to Hospitals

A glider service was inaugurated in the European Theater this month to evacuate our wounded from Remagen. Observers reported that the shock incident to being "snatched" into the air was absorbed by an improved towing device. It is now possible that gliders may almost eliminate ambulances for hauling our battle casualties long distances over shell torn roads—giving them a faster, smoother ride to the hospital.

The gliders serve a dual purpose. Coming into the battle area they can carry twelve litter patients or nineteen walking wounded.

Ambulance gliders were first used experimentally by the British in Burma and New Guinea.

## Maxillo-Facial Injuries

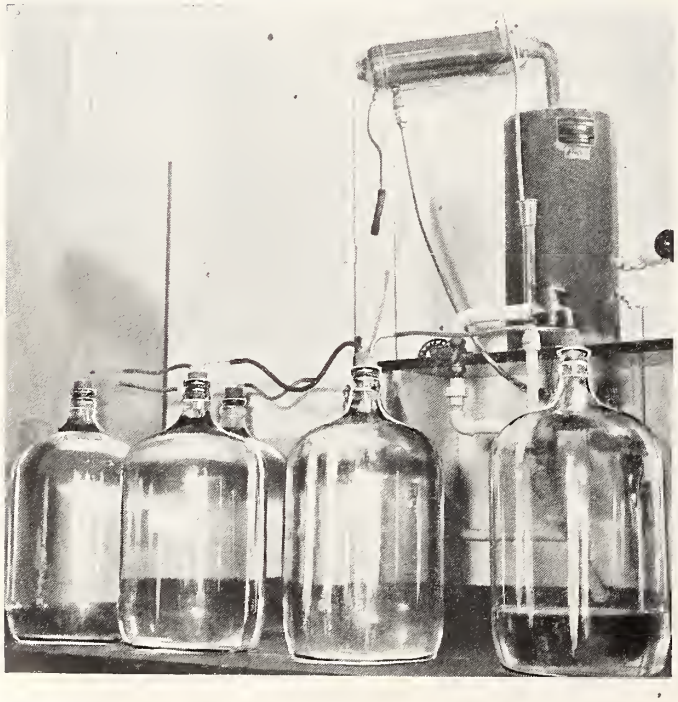
A survey of the North African and Sicilian campaigns showed that of the total admissions to hospitals 0.5 per cent were for maxillo-facial injuries. Of these, forty-two per cent were battle casualties.

The incidence of maxillo-facial injuries compared to total battle casualties was about 2.2 per cent. In the cases reported, there were no deaths caused primarily by battle-incurred maxillo-facial injury.

## Major Moore Operates a Continuous Still

One of the members of our State Society, Major Maurice R. Moore of Norwich, now stationed at Army Air Forces Regional Hospital, Greensboro, North Carolina, has discovered a method of supplying distilled water for an 800 bed hospital using a water still with an output of two gallons per hour. The secret is proper operation.

Six 5 gallon jars are connected in a series to the still by glass and rubber tubing. The jars are placed on a stand which is at least 40 inches below the level of the condenser. This establishes a fall sufficient to force the water through the sixth jar and creates a greater capacity than the still requires for 12 hours of operation. The full jars are replaced morning and evening, and no attention is required at other times.



Efficient operation of the unit depends on systematic removal of scales and sediment by draining and flushing daily and by cleaning the water chamber and steam coil chemically whenever the flow of distilled water is decreased. The still is filled up to the water level with 10 per cent hydrochloric acid which is allowed to remain 10 to 20 minutes. It is then flushed thoroughly with tap water. If the return flow contains large amounts of sediment, the procedure should be repeated until the drainings are clear.

## Army Achieving Speedy Expansion of Hospitals

The Army's expansion of its general hospitals by 70,000 beds is being rapidly accomplished through the conversion of existing buildings on hospital grounds rather than through new construction, according to the Office of The Surgeon General.

"At many of the general hospitals," said Brigadier General Raymond W. Bliss, USA, Assistant Surgeon General, "there are well constructed barracks, built with an eye to the future, which were used to house overseas hospital units during their training period. These barracks are now being turned into wards for patients. Permanent barracks, built to house the hospital staff, are also being converted into wards and are being replaced with temporary barracks which can be quickly constructed."

Over 50,000 more patients are being cared for in the Army's general hospitals than was the case in December 1944. During February about 1,200 casualties arrived from overseas daily.

## 193,000 Pints of Blood Flown to Wounded

Combined figures on East and West coast flights of whole blood to the war theaters reached 193,000 pints this month according to the Office of The Surgeon General. Since the start of the blood-flying program over the Atlantic last August, 150,000 pints of whole blood have been flown from the East Coast to the European Theater. This service has made it possible for a wounded man to get blood within 24 hours after it was drawn from a donor here. Shipments now average about 1,200 pints a day—which provides transfusions for three to four hundred average cases.

Whole blood shipments being flown from the West Coast to the Pacfiic Ocean Area have totaled 43,000 pints since the inauguration of the service last November.

Continued donations of type "O" whole blood are necessary to maintain this life-saving service.

## COMBAT BADGE FOR MEDICAL PERSONNEL

A special badge has been authorized for Medical Department personnel who daily share with the infantry the hazards and hardships of combat. Made of silver, the Medical Badge is elliptical in shape with the caduceus and the Geneva Cross superimposed on a litter surrounded by a wreath of oak leaves. It is to be worn on the left breast above decorations and service ribbons.

The badge was established in recognition of "the important role being performed by medical personnel on duty with infantry units, especially infantry battalions." Enlisted and officer personnel below field grade (major) and regimental surgeons regardless of rank are eligible for the badge if they have seen combat service with the infantry since December 7, 1941.

## GENERAL MORGAN HONORED

Brigadier General Hugh J. Morgan, USA, who is Chief Consultant in Medicine to The Surgeon General, has been named President-Elect of the American College of Physicians. Previously he was a member of the Board of Regents of the College.

## OFFICERS COMPLETE NEUROPSYCHIATRY COURSE

On the 19th of February, a class of 121 medical officers who had completed a three months' course in Military Neuropsychiatry were graduated from Mason General Hospital, Long Island, N. Y., Columbia University and New York University, New York, N. Y. These men will be assigned to various neuropsychiatric posts for hospital experience before being sent overseas. On that same day, a new class of 101 medical officers began at Mason General Hospital, under the Commanding Officer of the Hospital, Colonel C. C. Odom and the Director at the school, Colonel William C. Porter.

## FILM ON RECONDITIONING OF AMPUTEES RELEASED FOR PUBLIC SHOWING

"Swinging into Step," a motion picture which shows how soldiers who have lost arms or legs are prepared by the Army Medical Department not only for their return to civilian life, but for their "come back," has been released for public showing. Originally produced as a restricted "training film," for showing to the men, themselves, as soon as possible after they are wounded, this inspiring picture is now available to clubs, schools and other organizations as well as commercial movie houses. Requests should be directed to the Public Relations Officer of the nearest Army hospital.

The scene opens with three men in wheel chairs playing cards on the sun deck of a hospital ship en route home. One has lost an arm, one has lost a leg, and the third has lost both legs. In the background other wounded soldiers are amusing themselves, apparently light-heartedly, but the conversation of the three quickly reveals what must be in the minds of all: their doubts and fears of the future.

Reassurance is given by a Medical Corps Major who was an orthopedic surgeon—before he lost his arm. Over his voice the picture shows what happens to soldiers similarly wounded. How they learn to use their artificial arms and legs and finally are able to resume normal living. Further reassurance—as to how women react to disabled men—is given through the candid anecdotes of an Army nurse.

The War Department decided to release this film not only because of its informative value but to encourage a proper attitude on the part of the public toward disabled soldiers. The film is also of interest to medical men because of its portrayal of the Army Reconditioning Program.

## Promotions — Changes of Station

Major Thomas Raymond Preston, AUS, Hartford, has been promoted to Lieutenant Colonel.

Capt. Harold Strickland, AUS, Meriden, has been home on leave and is now in North Carolina awaiting reassignment.

J. L. Roy, AUS, North Grosvernordale, has been promoted to Major and is serving as Post Surgeon at the Miami Beach Service Base (ATSC), Miami Beach, Florida.

First Lieutenant Paul P. Duzmati, AUS, Bridgeport, has been promoted to Captain, stationed overseas.

Captain Sam B. Kirby, AUS, New Haven, has been promoted to Major and is stationed overseas.

Captain Frederick C. Weber, Jr., AUS, Greenwich, has been promoted to Major, stationed overseas.

Lieutenant Commander Anthony A. Apuzzo, (G), USNR, Middletown, has been transferred from Harts Island, New York, to Camp Peary, Williamsburg, Virginia.

## War Medicine: Vol. 7, No. 2, February 1945

The longest article in this issue of *War Medicine* discusses "Interservice Consultations in One Army General Hospital" and is by Lieut. Col. Samuel Morrison, MC—AUS. It stresses the benefits accruing from this method which is similar to that practised in the best civilian hospitals. Tsutsugamushi fever, better known as scrub typhus, appears in two papers, one recording observations in 195 cases, the other pointing out the cardiac complications. Both papers call attention to the transitory phase of damage produced, once the acute stage is over.

Captain James L. Tullis, MC—AUS, reports seven cases of typhoid fever in previously immunized subjects. Ten cases of hemoglobinuria are reported in Negroes during convalescence from malaria. Major W. F. Ashe, Jr. and Major L. B. Roberts,

MC–AUS, submit a short report on "Experimental Human Burns." The results of sensitvity of bacteria from infected wounds to penicillin in 112 cases are reported by Captain Edward Gollardo, MC–AUS. A study of 53 isolated strains of paracolon bacilli is the work of two Army officers. They find evidence that under conditions of poor sanitation these organisms may assume an important role in the causation of acute gastroenteritis.

The Abstracts from Current Literature represent publications from Germany, France, New Zealand, Australia, Canada, the British Isles and the United States. One book review only is included. There is a very pertinent letter on "The Role of the Rh Factor in Blood Transfusion" which contains information worth noting.

By some strange coincidence (or was it intentional?) the U. S. Navy is not represented in any of the articles in this issue.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Lieut. Col. Robert P. Rogers, AUS, Greenwich

8 March 1945

In your issue of December I saw letters from several friends of mine. I enjoyed them so much that I have decided to write also.

My army career has been extremely varied. After an interesting year with the medical services of the Army Air Forces during which there was a red letter interval at the Army Medical School at Walter Reed Hospital in the course on Tropical Medicine, they sent me from a very nice post at Langley Field by telegraphic orders to the Yale School for Civil Affairs.

There at Yale among other things we were supposed to become Italian speaking public health experts in three months. After 6 weeks, however, we were rushed overseas in a 28 day Liberty ship rush arriving at Sicily entirely by mistake. (We were supposed to go to Algiers but the boat wouldn't stop there so we didn't.) We were apprenticed so to speak to the field workers in Sicily and had a very interesting 2½ months there. It appeared that the authorities in Africa didn't know where we were for a whole month in spite of our sincere efforts to reach them. However, the authorities in Sicily were very glad to have us and enrolled us straightaway.

The next four months following Sicily were one of the most interesting four months I have ever had. It was my good fortune to get connected with Dr. Soper from the Rockefeller Institute and his excellent crew and later to be loaned to the Typhus mission. It was also my good fortune to head up the Immunization Department under that commission. It was the thrill of seeing put to test a new method of control and of seeing it work.

Aside from the medical end of things to see Vesuvius blow its top off and watch that gigantic phenomenon of nature made my stay in Naples a tremendous memory.

At the end of April I was available for a new adventure and was whisked off to Africa in a sort of hush hush group. Great events were expected. As you now know these events did not take place until August. In the meantime we entered a mark time period in a delightful spot on North Africa where we were supposed to become French speaking individuals. These mark time periods are trying no matter how delightful the spot, but the army seems to be that way, great or intense activity and then mark time.

Before the invasion of Southern France I had three interesting weeks back in Naples with the planning group during which time I did get up to Rome. The invasion experience itself was one I never would have missed after it was over but during it there were times when I wondered what business I had doing there anyway. I was on one of the Headquarters boats and got up early on D day to see things begin. We saw the first flashes followed by the first sounds of the invasion in the early gray of the morning. We were landed D plus 1 and from then on life was very busy for awhile. I was Chief Public Health officer G-5 7th Army at this particular period. We found it hard to keep up with the army, in fact we couldn't as most of our work kept us in the cities along the Mediterranean.

Later I was transferred to G-5 6th Army Group as Chief of the Public Health Division where I still am and am expecting an entirely new and interesting chapter just ahead.

Robert P. Rogers

## From Captain Frederick E. Mott, AUS, New Haven

22 March, 1945

Please place my name on the mailing list for the CONNECTICUT STATE MEDICAL JOURNAL. At the present time I am stationed in the Philippines with a heavy bomb sqdn., and I would appreciate receiving the JOURNAL. Thanking you in advance for your attention and interest.

Frederick E. Mott

## From Captain Francis L. Lundborg, AUS, West Hartford

Somewhere in France
8 March 1945

Here I am on the continent and to date have not met any of our men. Petey Hough was my last contact and I understand he is headed for parts unknown. At the moment personal quarters is a pyramidal tent containing 4 officers—cots, personal equipment and a big stove. Our wood and coal supply is rationed so we do not have too much heat at one time or for a prolonged period. Our lighting is candle power by which we write and read. Water is rationed and we do not bathe too frequently. One compensation is a good mess—excellent in fact, our personnel being the best. Remember me to everybody.

Francis

France
29 March 1945

Just a few lines from a place further along on my journey. I have stopped off in England and seen London in part—and would like to see more of it. Have gone through part of France and found (where the war has not hit the countryside) the farms beautiful. Being time for spring plowing the farmers were out doing it. Various early flowering shrubs like forsythia are now blooming. Have been in to Paris but as yet not to the Follies Bergere which is a high class burlesque from reports. I have a lot more of it to see. As a surprise to you—I have a bottle of prized cognac still untouched and on the glorious V day and if I have a D-(departure) day I will surely open it and imbibe some. Remember me to the men at the hospital. Best wishes.

Francis

## From Captain T. J. Valenski, AUS, Thompsonville

Somewhere in France
23 March '45

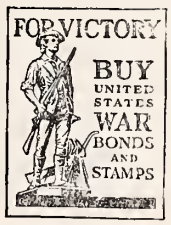
In reply to your letter which finally reached me I can simply say that I've been on the surgical service aboard the U. S. Army Hospital Ship, - - - since July 4, 1944. At present we are about to load patients in a port somewhere in France. Our home base is Charleston, S. C. Thus far we have made many trips back and forth to the States and have been kept very busy with so many casualties.

In civilian life my home and office are in Thompsonville, Conn., and am on the Springfield Hospital (Mass.) surgical staff. Since Springfield, Mass., is so nearby many of us only do our work in the hospitals there. Consequently I have never had the pleasure and opportunity of meeting many of my medical colleagues in and around Hartford, Conn.

T. J. Valenski

## A. M. A. House of Delegates

American Medical Association officials are conferring actively with Office of Defense Transportation to secure opportunity for House of Delegates of the Association to meet in May or June if possible. Indications are that meeting may be postponed until August or later.




MAKING A MOUNTAIN OUT OF A MOLE — is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## NEWS FROM WASHINGTON

Watchers along the Potomac and commentators on the national scene, both amateur and professional, are in general agreement that the Wagner-Murray-Dingell Bill that would impose a three billion dollar compulsory health insurance system on America is a dead duck. However, there is equally unanimous opinion that new proposals for the extension of medical care are coming, and very soon. There has been a good deal of speculation as to what these proposals will be and what direction they will take. Left-wing partisans are sure things are going their way and conservatives believe that no great changes will be made in the pattern of American medical care.

Almost everyone is optimistic about the passage of the Hill-Burton Bill, S. 191. This is a Hospital Study and Construction Bill which will carry out recommendations made by Surgeon General Parran and the Senate Sub-Committee on Wartime Health and Education. The Hill-Burton Bill is looked upon as a conservatively constructive measure, except by the die-hards who believe any intercession of the federal government in individual medical care is a step toward communism. The bill, if it becomes a law, will provide funds for study of medical care and hospitalization within the states by a state agency with the advice of a medical advisory committee to be set up locally. All the way through, this bill seems to place emphasis upon the importance of local interpretation of needs and local autonomy of administration.

The Board of Trustees of the American Medical Association and the American Hospital Association have endorsed the Hill-Burton Bill. Some changes in it have been suggested but none of these are such as to provoke prolonged delay in Congressional action. It is likely that some of the favorable response and support that is being given to this measure stems from the intent of the Pepper Committee to use the proposed hospital construction as a post war project to provide employment and round out the public works program, and at the same time extend hospitalization for civilians.

There seems to be a rather general feeling in Washington that a new "Wagner" bill will be introduced to this session of the Congress. The first and second bills introduced by Senator Wagner and his colleagues brought forth a great fire of criticism from many sources, particularly medicine and industry. The only ones who were in general accord were the left-wing social betterment groups and labor that seemed to feel that it was getting a good deal for nothing. It is suggested that some of the objectionable features will be missing when Senator Wagner introduces his next social security-health insurance bill which will also bear his name as he seems avowed to leave it as a monument to himself when he leaves the Senate, as some day he must.

The procedure of the Committee on Health and Education, the socalled Pepper Committee, in contrast to the methods of Senator Wagner and his group, are remarkable. No one has ever been informed as to how much expert technical medical advice Senator Wagner has had in conceiving and drafting his legislation and whatever advice he did have appears to have come from social reformers rather than from persons experienced in providing medical care. This has been a frequent cause of objection to the philosophy set forth in Senator Wagner's proposed legislation. On the other hand, the procedure and reports of the Senate Sub Committee on Wartime Health and Education show that the Committee has sought information and advice from many skillful people who have had long and progressive experience in the distribution of medical care. The Committee has received generous com-

mendations from spokesmen for medicine and others and its studies and deliberations have been welcomed as the only scientific approach to a health program that is being offered in Washington today.

The Hennepin County Medical Society, Minnesota, which has a close approach to Congress, believes that Senator Pepper has indicated something of his views on a national health program. "He has shown a sympathetic attitude towards voluntary prepaid medical care plans but insists that these, to accomplish the ends sought, must provide complete, rather than limited, coverage and must be offered at low cost. On the matter of low cost he has been most emphatic and has suggested that these costs should be fairly uniform. Medical care, in his thinking, includes not only care by physicians but hospitalization and dental services as well. Apparently this concept of 'complete medical care,' is shared by members of his committee. Repeatedly he has sought to draw witnesses into discussions of the idea of federal grants to states or even groups which have acceptable prepaid medical care plans, not suggesting federal control but rather a broad system of subsidies to assist these plans to reach all elements of the population and to operate more effectively. In this, he has been seeking the advice and opinions of others, not necessarily expressing his own ideas. There can be no doubt that Senator Pepper understands the desirability of quality medical care: he has been very definite on that point. Finally, he has expressed doubts that the American people are now ready, if ever they will be, for a compulsory health insurance plan. This last is particularly illuminating in the light of Senator Wagner's proposals.

"It should be obvious that these two men approach the matter of a national health program from widely divergent points of view and with sharply contrasting backgrounds. Senator Pepper has sought the suggestions of interested parties of all shades of opinion, has endeavored to reconcile these conflicting ideas and has indicated a broad concept of the problem. Senator Wagner, on the other hand, apparently has been content to listen only to the views of social planners and functionaries of the Social Security Board."

Washington agitation is mounting over medical services in the Veterans Administration. Articles by Albert Q. Maisel (*Cosmopolitan Magazine*, March 1945), a long series in *PM*, and news items in many papers show public interest. In an interview General Hines says that charges that the Veterans Administration hospitals are giving third-rate medicine to war veterans and following antiquated methods in their operation are entirely unfounded. "The medical service of our hospitals is up to the highest professional and ethical standards of the medical profession and our hospitals are on a par with any in this country." The Military Affairs Committee of Congress proposes an investigation of the medical service in the Veterans Administration. The Subcommittee on Health of the Committee on Education and Labor is also investigating.

## On Capitol Hill

The Connecticut General Assembly of 1945 has now been in session for more than three months. The period for the introduction of new legislation closed on February 2 and since that date the members of both Houses have been occupied in reviewing the proposed bills and resolutions which numbered over 2,000. This process in our State is a deliberate one and at the present writing the final passage or rejection of legislation has been effected in a minority of instances.

Committee hearings have been held, however, on nearly all of the bills relating to public health and welfare and it is expected that the legislature will take action on many of these measures before the first of May.

Seven bills which are of interest in medical and allied fields have been passed by the Senate and the House of Representatives and will in most cases become law in July. These additions to the Statutes are:

S129—An Act concerning the Use of Roentgen-Ray, X-Rays and Radium.

This act permits the use of Roentgen-rays, x-rays or radium for therapeutic or cosmetic purposes only by licensed physicians, osteopaths or dentists.

S130—An Act concerning the Observation and Treatment of Germ Carriers.

The State is authorized by this act to pay the costs of hospital care and medical treatment of suspected as well as proved carriers.

S249—An Act concerning the Care of Crippled Children.

The terms "poor," "destitute" and "indigent" are eliminated from the statutes pertaining to the care of crippled children.

S288—An Act concerning the Incorporation of Grace-New Haven Community Hospital and Au-

thorizing Its Consolidation with the General Hospital Society of Connecticut and with Grace Hospital Society.

The combination under one management of all the property and activities of the Grace Hospital Society and the General Hospital Society (New Haven Hospital) is authorized.

H193—An Act Defining Narcotic Drugs.

Isonipecaine (Demerol) is included as a narcotic drug in Subsection 14 of Section 970c of the 1935 supplement to the General Statutes.

H811—An Act concerning Insane Patients; Parole; Temporary Absence.

Insane patients are permitted by this act to remain on parole with relatives, etc., for one year instead of six months.

H814—An Act concerning the Establishment of a Joint Committee of the State Mental Hospitals.

The informal joint committee of the state mental hospitals and training schools is given legal status by this act.

The House of Representatives has rejected two bills which were generally looked upon as constructive measures:

H196—An Act concerning District Departments of Health.

This measure, which has been rejected by previous sessions of the General Assembly, would permit two or more towns, cities or boroughs to unite to form district health department. Participating towns, etc., would receive grants from the State.

H602—An Act Establishing a State Plan for Mental Health. This act would provide for the establishment of psychiatric clinics at the state mental hospitals and training schools, expansion of the program of the Bureau of Mental Hygiene and development of psychiatric services for children.

This bill in particular was widely supported but the appropriation of $331,329 which it carried may have influenced the legislators.

An unfavorable report of the Public Health and Safety Committee on *H. 192, An Act concerning Exemptions,* was accepted and this bill, which would have prohibited the sale of paregoric without prescription, was rejected.

The remainder of the bills which were summarized in the March issue of the JOURNAL have been heard before the various committees but have not as yet appeared on the Senate and House calendars. Dr. James Raglan Miller represented the Society at the hearing on March 27 of *H. 601* (s. 754) *An Act concerning the Establishment and Administration of a System of Health Insurance and Making an Appropriation Thereof.* The measure was also opposed by spokesmen for the Christian Scientists and the Manufacturers Association.

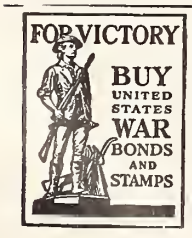
Representatives of twenty-one examining and licensing boards turned out in force to register opposition to *H. 1031, An Act concerning Examining and Licensing Boards and Commissions and Establishing a Department of Professional and Vocational Licensing.* It seems probable that this bill will not be passed.

No prediction can be made on the fate of H. 144, which creates a commission on the care and treatment of the aged, infirm and chronically ill people of the state. The hearing, however, was largely attended and the establishment of such a commission is being sought in many quarters.

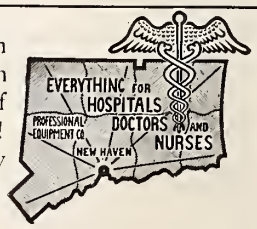
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## Fertility

The Bureau of Census, if anyone is interested, has a new and exciting publication, there are 265 pages and it weighs about a pound. Its subject is "Fertility Differential." The government does wonderful things and in this book is a discussion of "Smooth Figures, Computed by Fifth Difference Osculatory Interpolation." And here is the nub—women migrating from urban to rural areas are somewhat more fertile than women migrating from rural to urban areas. The whole affair probably has something to to with the sociological phase of the "war effort," but a distinguished contemporary suggests that it is Spring.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# ANNUAL REPORTS

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

## 1944 - 1945

### REPORT OF THE TREASURER

The House of Delegates
Connecticut State Medical Society
Gentlemen:

The statement of Seward and Monde, Certified Public Accountants, appears in the agenda for the House of Delegates, May 23, 1945, and will be published in a subsequent issue of the JOURNAL. This statement presents simply and concisely the financial activities of your Society for the calendar year 1944.

As in the previous year, a part of the excess of income over expense has been invested in Government Bonds.

At the annual meeting held in Bridgeport, May 2, 3 and 4, 1944, the recommendation of a special committee that the State dues be collected through the State Office was tabled. It was suggested that the committee confer with the County Secretaries and develop a substitute arrangement agreeable to the component organizations. The committee has not as yet complied with the instructions of the House of Delegates, but hopes to do so within the next few months.

To Seward and Monde, who continue to render to us so graciously expert advice and supervision, and to Dr. Barker and his efficient staff, who carry the burden of the many financial details incidental to the office of Treasurer, I express my sincere thanks.

Respectfully submitted,
Hugh B. Campbell

### REPORT OF THE AUDITORS

Mr. President and Members of the House of Delegates of the Connecticut State Medical Society:

Through the statement of the Trust Department of the Second National Bank of New Haven, dated March 10, 1945, we have today reviewed the securities and bankbooks comprising the assets of the O. C. Smith and Gurdon W. Russell Funds. They are as follows:

O. C. Smith Fund:

Savings Passbook No. 55673 evidencing a balance of $1,006.25, Mechanics Savings Bank, Hartford.

Savings Passbook No. 134553 evidencing a balance of $406.80, Mechanics Savings Bank, Hartford.

Russell Fund:

$1,000 par value Boston and Albany Railroad Company Improvement Bond of 1928 4¼% due August 1, 1978—No. 4222 with February 1, 1945 and subsequent coupons attached.

$2,000.00 par value The Consolidated Railway Company 4% Coupon Debenture due July 1, 1954 Nos. 3525 and 3526 for $1,000.00 each with July 1, 1942 and subsequent coupons attached.

$5,000.00 par value United States of America Treasury Bonds 2¼%—1956-59 due September 15, 1959—Nos. 91261A, 91262B, 91263C, 91264D and 91265E for $1,000.00 each with March 15, 1945 and subsequent coupons attached.

Savings Passbook No. 55057—Mechanics Savings Bank, Hartford. Connecticut, evidencing a balance of $2,760.24.

Signed:
Chas. T. LaMoure
Floyd A. Weed

### REPORT OF THE EDITORIAL BOARD OF THE CONNECTICUT STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

During another calendar year the JOURNAL has gone forth to members of our Society, not alone in the United States, but literally in the four corners of the earth. Very gratifying have been the replies received from many of our readers, testifying to the value of an up to date mailing list which we have endeavored to maintain at our Hartford office with the assistance of the Secretary's office in New Haven. Our success in this endeavor is not complete for many months have passed in some instances before we have caught up with a wandering medical officer.

We have kept to the pattern of four special issues during the year, the Convention Number in May, the Roster Number in August, the Clinical Congress Number in September, and the Army-Navy Number in December. In the Convention Number were carried fifty-seven pages of advertising, much of it a special feature of that issue. The Army-Navy Number contained a complete roster of member physicians in military service, together with many interesting letters from some of this group, and an account of a well baby clinic in the Fiji Islands by Major Russell V. Fuldner. The Horace Wells Centenary held in Hartford on December 11 received a modest share of publicity.

The same departments have been continued, except that *Across the Continent* completed its appearance with the November issue, to give way to a department devoted to the new Woman's Auxiliary. *Medicine and the War* has grown in size as one would expect, while the difficulty in securing physicians with time to contribute to *New Books in Review* became more and more evident as the end of the year drew near.

The Journal Board has held but two meetings during the year. At one of these Dr. Theodore Klumpp, president of Winthrop Chemical Company, was our guest. At the other meeting we listened to a projected plan for advertising by Mr. Hubert S. Mayrand. On the occasion of some of the visits of Mr. Sandberg, director of the Cooperative Medical Advertising Bureau of the A.M.A., a few of the Board have been called together on short notice for discussion of advertising policies. The planning of the monthly issues has been done, for the most part, by the Literary Editor, the Managing Editor and the Secretary of the Society together in conference.

We feel justly proud of the scientific papers collected by Dr. Thoms and of the editorials written in a large measure by him. Dr. Barker and Miss Mooney have assisted in maintaining many of the departments of the Journal. Both Miss Mooney and Mr. Mayrand, the latter for four months during the late fall and winter, covered many important gatherings and reported them in the Journal.

A cursory glance at one of the recent issues will convince any one that The Journal has acquired an increasing amount of advertising. much of it in color. This is a trend in medical journal advertising which, when wisely pursued, adds life to a publication. Not all our advertising is Council-Accepted since the Board still adheres to the policy of presenting products of wide usage which are safe and of proven value. In these decisions we have not hesitated to seek the advice of one of our members, Professor William T. Salter of Yale University School of Medicine, as well as many distinguished Connecticut clinicians.

Our printer, Whaples-Bullis Company, deserves much credit for helping us to maintain a publication which to all appearances has suffered little from the casualties of war. This has been done by some personal sacrifice on the part of the printer as well as by good management and ceaseless effort. Looking over the group of state medical journals, we feel extremely fortunate in the choice of our printer.

Mrs. Priscilla Hume has continued with us through the year at the Hartford office, a fact which has meant much to the Managing Editor whose professional duties have increased as the war has continued. It has been a full year and yet the satisfaction of producing for our members a monthly journal of some value from an informative as well as a scientific standpoint has been sufficient compensation for the efforts of the editors and Board members. We appreciate the interest of our readers and bespeak your loyal support as we endeavor to bring you a better Journal in 1945.

Respectfully submitted,
Stanley B. Weld

## REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE — THE CONNECTICUT MEDICAL EXAMINING BOARD

Charles J. Bartlett, President

| | |
|---|---|
| Thomas P. Murdock | George M. Smith |
| Daniel C. Patterson | John C. Rowley |

Creighton Barker, Secretary to the Board

For the year of 1944 the Connecticut Medical Examining Board held three regular written examination sessions and three oral credential examinations in compliance with the Medical Practice Act of Connecticut and, to meet the exigencies of war time, three special oral credential examinations were held also. By this it was possible for physicians licensed in other states or by the National Board of Medical Examiners to have an opportunity to obtain a license to practice in this state by endorsement once in every two months throughout the year.

Twenty-six candidates were successful in the written examinations and recommended for licensure. Eleven candidates failed the written examinations and were not recommended for licensure.

Seventy-seven candidates were successful in the oral credential examinations and were recommended for licensure. Fifteen candidates were unsuccessful and were not recommended for licensure. Under regulations of the Board candidates are not permitted to repeat the oral credential examination and those not successful in that examination are required to take the regular written examination in order to obtain recommendation.

Successful candidates were graduates of the following medical schools: Harvard–11, Yale–11, Long Island College–8, University of Rochester–6, University of Vienna–6, New York University–4, Tufts–4, University of Chicago–3, Columbia–3, Georgetown–3, University of Maryland–3, McGill–3, Temple–3, University of Pennsylvania–3, Boston University–2, George Washington–2, Johns Hopkins–2, University of Paris–2, Washington University–2, Albany–1, Cornell–1, Jefferson–1, Louisiana State University–1, Loyola–1, Northwestern–1, Ohio State–1, St. Andrews, Scotland–1, Western Reserve–1, University of Budapest–1, University of Buffalo–1, University of Cologne–1, University of Freiburg–1, Laval University–1, University of Minnesota–1, University of Nebraska–1, University of Texas–1, University of Toronto–1, University of Vermont–1, University of Western Ontario–1, University of Wisconsin–1.

Unsuccessful candidates were graduates of the following medical schools: University of Vienna–5, Long Island College–3, Baltimore Medical College–1, George Washington University–1, Johns Hopkins–1, Laval University–1, Meharry–1, New York Medical College–1, New York University–1, University of Breslau–1, University of Chile–1, University of Cincinnati–1, University of Geneva–1, University of Hamburg–1, University of Minnesota–1, University of Montreal–1, University of Paris–1, University of Turin–1, University of Vermont–1, and Womans' Medical College of Pennsylvania–1.

Credential candidates presented the following credentials: National Board of Medical Examiners–41, New York–26, Ohio–5, Massachusetts–4, Vermont–4, Maryland–3, Illinois–2, Pennsylvania–2, Iowa–1, Maine–1, Missouri–1, New Jersey–1, Oregon–1 and Texas–1.

Of the total examinations given 113 were given to males of which 93 were successful and 20 (or 17.7 per cent) failed. Sixteen examinations were given to females of which 10 were successful and 6 (or 37.5 per cent) failed. This produced a consolidated failure rate of 20.1.

Twenty-five examinations in medicine and surgery were given to Doctors of Osteopathy: i.e., 15 examinations in

Medicine with 1 successful result and 10 examinations in Surgery with 4 successful results.

## REPORT OF THE COMMITTEE ON THE CLINICAL CONGRESS

Francis G. Blake, *Chairman*

Herbert Thoms — James R. Miller
Charles E. Sanford — Creighton Barker
H. Gildersleeve Jarvis — Stanley B. Weld
Louis H. Nahum

The Twentieth Clinical Congress of the Connecticut State Medical Society was held at the New Haven Lawn Club on September 28 and 29, 1944.

Despite the war the registration was very satisfactory, the total being 503. Of these 92 per cent were from Connecticut, 8 per cent from outside the State, chiefly from the neighboring States of New York, Rhode Island, and Massachusetts. An analysis of the registration figures prepared by Maurice J. Strauss, Chairman of the Committee on Publicity and Registration shows that the registration of members of the Connecticut State Medical Society was considerably larger than in 1943 (396 as against 328), the percentages of the members of the various county societies who registered being comparable to those of the preceding year except for increases from Fairfield, Litchfield, and Windham Counties. The number of new registrants was 103 or 20.5 per cent, of former registrants 400 or 79.5 per cent, figures which make it evident how much the Congress is dependent for its support on a large group of "regulars" who return year after year.

The report of the Treasurer, Charles E. Sanford, for the year ending December 31, 1944 is as follows:

RECEIPTS

| | | |
|---|---|---|
| Registration Fees and Luncheons | $1,113.00 | |
| Interest, New Haven Savings Bank | 67.84 | $1,180.84 |

DISBURSEMENTS

| | | |
|---|---|---|
| Printing | $177.25 | |
| Clerical work | 195.87 | |
| Dinners and Luncheons | 362.65 | |
| Speakers' expenses | 31.82 | |
| Miscellaneous | 316.03 | |
| Total | $1,083.62 | |
| Surplus | 97.22 | $1,180.84 |

ASSETS

| | |
|---|---|
| Cash in New Haven Savings Bank | $3,443.47 |
| Cash in New Haven Bank N. B. A. | 419.91 |
| | $3,863.38 |

It is gratifying to note that there was a modest surplus of $97.22, which should be attributed to the economical and efficient work of all the committees concerned, and especially the Committee on Arrangements under the chairmanship of John C. Mendillo.

As usual, the program committee under the able guidance of Louis H. Nahum provided an excellent program nicely balanced and of wide interest. The two morning sessions dealt with a variety of currently important subjects. One of the afternoon sessions consisted of a symposium on penicillin and its therapeutic applications, the other of demonstrations on the treatment of burns and the care of extremities with deficient arterial circulation.

On behalf of the officers of the Clinical Congress I wish to express their appreciation for the services of the many physicians generously given, which make the Congress a success year after year.

Respectfully submitted,
Francis G. Blake

## REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

B. M. Parmelee — Louis P. Hastings
H. G. Jarvis — Sanford H. Wadhams
Creighton Barker — Harry S. Frank
Charles T. Flynn — Edmund L. Douglass
James R. Miller — Donald M. Beckwith
Andrew O. Laakso

The Committee met February 25, 1945 at the State Medical Office in New Haven. Present were Berkley M. Parmelee, Louis P. Hastings, Charles T. Flynn, Edmund L. Douglass, Donald M. Beckwith, James R. Miller, Joseph H. Howard, Creighton Barker and Dr. Osborn, State Commissioner of Health, by invitation. Dr. Barker had prepared a list of bills which concerned public health and welfare which had been introduced to the Legislature. The title and purpose of each Bill was discussed and a decision made to support, oppose or stand neutral in the Public Hearings before Legislative Committees. In general, the Committee's stand was to support all sound progressive legislation.

All bills sponsored by the Connecticut State Medical Society, the Connecticut Hospital Association, the State Board of Health, and the Connecticut Hospital Service were approved. The osteopathic bill was considered to be essentially non controversial this year. Opposition was expressed to a bill concerning the license to practice pharmacy, because it appeared to lower standards for licensure.

A bill concerning the establishment and administration of a system of compulsory health insurance was discussed at some length. Because of its many controversial features, opposition to it was expressed. The public hearing on this bill has already been held. James R. Miller represented the Society at the hearing and he plans to submit a detailed report in the near future in the Connecticut State Medical Journal.

Respectfully submitted,
B. M. Parmelee

## REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

James R. Miller, *Chairman*

Thomas P. Murdock — C. Charles Burlingame
Creighton Barker

As a committee there has been no activity to report. Your attention, however, is called to the increasing acuteness with which national legislation is being followed gy representa-

tives of the American Medical Association and to the promptness with which reports of happenings in Washington are brought to the attention of members of the Society.

Respectfully submitted,
James R. Miller

## REPORT OF THE COMMITTEE ON PREPAID MEDICAL SERVICE

J. Harold Root, *Chairman*

| | |
|---|---|
| Thomas P. Murdock | Stanley B. Weld |
| Berkley M. Parmelee | George M. Craig |
| James R. Miller | Richard E. Dunne |
| Herbert Thoms | H. M. Marvin |

William H. Weidman

Since the last meeting of the House of Delegates, December 7, 1944, progress has continued in the development of the prepaid medical plan, although unforseen circumstances have caused delay.

At a meeting of the Board of Directors of Connecticut Hospital Service, Incorporated, January 19, 1945, considerable discussion occurred as to whether Connecticut Hospital Service legally had the right to participate in the Medical Plan as outlined in your committee's last report, particularly as to whether it might lose its status as a non profit organization. The board finally voted to authorize Mr. Hoit to employ legal counsel and to further take any necessary steps which would permit the Hospital Plan to legally participate in such a medical service plan.

After consultation with, and approval by, the insurance commissioner and his staff, the enclosed bill was introduced in the General Assembly. A hearing on this bill was held in March at which no opposition to the bill developed.

Dr. Barker and Mr. Hoit have in the meantime made excellent progress in getting the plan into its final draft. At a meeting of your committee in February, certain features in the plan were discussed and suggestions offered to Dr. Barker.

Further progress awaits action of the Legislature on the bill, which we have every reason to believe will be favorable. The new corporation can then be formed and contract accepted either in its present or possible further revised form.

A joint meeting of your Committee and the Committee on Medical Service Plans from Connecticut Hospital Service, Incorporated, was held on April 11. After lengthy discussion it was decided that the medical society should employ counsel at once to draw up articles for the formation of a new corporation.

It was agreed that the members of this corporation should be six physicians representing the Connecticut State Medical Society, and five laymen to be chosen by the Medical Society. The five laymen are to be carefully selected from public minded citizens who are best qualified to serve in the public interest in the development of a sound Medical Plan, along the lines already suggested, and its sale to individuals in Connecticut.

Respectfully submitted,
J. Harold Root

### House Bill No. 999

An Act empowering the Connecticut Hospital Service, Incorporated, to contract with and act as agent for medical service corporations.

Introduced by Mr. Thim of Hamden.

Referred to the Committee on Judiciary.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The Connecticut Hospital Service, Incorporated, a corporation formed prior to July 1, 1939 under the general laws of the State and ratified and approved subject to the provisions of Chapter 192a, Laws of Connecticut 1939, and its successor or successors are hereby authorized and empowered to enter into contracts with and act as agent for any medical service corporation or corporations organized under chapter 192c of said laws of 1939 for the purpose of carrying on the business and operations of such medical service corporation or corporations.

Section 2. The Connecticut Hospital Service, Incorporated, its successor or successors shall have the right to charge reasonable compensation for any services rendered under contracts or agencies as provided in Section 1 hereof, but nothing herein contained shall change the status of said corporation as a non profit sharing corporation, and any compensation received under this act shall not inure to the pecuniary benefit or profit of any officer, member, agent, employee or incorporator of said corporation, except reasonable compensation may be received by such officers, members, agents, employees or incorporators for services rendered.

Section 3. The Connecticut Hospital Service, Incorporated, its successor or successors are authorized and empowered to contribute to any medical service corporation with which it or they may contract, or for which it or they may act as agent, an amount not in excess of $5,000, and not more than 50 per cent of the security which may be required of such medical service corporation by the insurance commissioner as a guarantee of the performance of the obligations of such corporation.

Section 4. Any medical service corporation organized under Chapter 192c of the Laws of Connecticut 1939 is hereby authorized and empowered to enter into contracts and appoint Connecticut Hospital Service, Incorporated, its successor or successors as its agent for the purposes herein expressed.

Section 5. This act shall take effect on its passage.

### Statement of Purpose

To permit the Connecticut Hospital Service, Incorporated, a corporation now subject to the provisions of Chapter 192a, Laws of Connecticut 1939 to enter into contracts with and to act as agent for medical service corporations organized under Chapter 192c of the Laws of Connecticut 1939, and to make contribution to the security guaranteeing the performance of the obligations of such medical service corporations with which it may contract, such guarantee being required by the provisions of Chapter 192c; and further to authorize medical service corporations organized under said Chapter 192c to enter into such contracts and appoint Connecticut Hospital Service, Incorporated, as its agent.

## REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Howard S. Colwell, *Chairman*

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| Donald A. Bristoll | Karl T. Phillips |
| Jessie W. Fisher | J. Harold Root |
| Albert C. Freeman | Howard G. Stevens |
| Joseph H. Howard | Maurice J. Strauss |
| Joseph I. Linde | Oliver L. Stringfield |
| Luther K. Musselman | Carl L. Thenebe |
| Mario L. Palmieri | Friend L. Mickle—Associate |

The Emergency Maternal and Infant Care Program for wives and children of Service men has continued to demand much consideration by the Public Health Committee. This program is expanding its services to include health supervision of infants up to one year of age either in the doctor's office or at a Well-Baby Conference. Immunizations are included.

The Children's Bureau of the State Department of Health charged with carrying out this program, in addition to its efficiency in supervising the services and care in accordance with the act of Congress, has also been most cooperative in understanding the position of the doctors of the state; in presenting to the United States Children's Bureau in Washington the point of view and recommendations of our Committee; and in simplyfying as far as possible the complicated problems of administration.

The attitude of the Public Health Committee toward the F.M.I.C. program continues to be that expressed by the Council of the State Society over a year ago to the effect that we are willing to cooperate but that we cannot approve the program as it is set up. The program is arbitrary in many of its requirements and stipulations; gives us no share in its formulation; appears to give only casual attention to our recommendations to Washington; fails to grant any appreciation to cooperating physicians.

The Committee has cooperated with the War Food Administration in its supervision and regulation of the sale and prescription of heavy cream. At present physicians of Connecticut have satisfactorily rearranged prescribed diets so that requests for 40 per cent cream are rare.

The continuation of evaluation of serological laboratories throughout the state by the Connecticut Department of Health has been watched with interest and approval.

Recommendation has been made that the Laboratory of the Connecticut State Department of Health and all hospital laboratories doing prenatal serological tests do determination of the Rh factor on such specimens for the purpose of lowering maternal and infant morbidity and mortality.

In order to continue to improve our situation in the lowering of maternal deaths, we have requested the STATE MEDICAL JOURNAL to publish at intervals reports and discussions of maternal deaths. To obstetrical services in hospitals throughout the state, we have sent reminders of the importance of autopsies in all cases of maternal death.

Among the matters which continue to demand our attention are:

(a) Full time public health service for numerous communities, either by themselves or in conjunction with adjoining communities.

(b) The desirability and necessity for higher percentages of immunized children—both as to diphtheria and small pox—in many communities.

(c) Furtherance of health education for both the public and physicians in fields not at present covered by any agency.

Respectfully submitted,
Howard S. Colwell

## REPORT OF THE COMMITTEE ON COOPERATION WITH YALE SCHOOL OF MEDICINE

James R. Miller, *Chairman*

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| Charles J. Bartlett | Charles T. Flynn |
| Berkley M. Parmelee | W. Bradford Walker |

During the past year no items have been brought to the committee for consideration. It is worthy to note, however, that some members of this committee by virtue of their membership on the Committee on Medical Care and Health of the Post-War Planning Board participated in a discussion with the Faculty Committee on Program Planning of the Yale Medical School. The question which was discussed was, briefly stated, the extent to which Yale Medical School would participate in a program of postgraduate education for the returning physicians after the war. At the time that this discussion was held, the Medical School did not contemplate developing postgraduate courses of instruction though it was hoped that Fellowships in postgraduate work of an investigative nature would be more plentiful than before.

Respectfully submitted,
James R. Miller

## REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

C. F. Yeager, *Chairman*

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|---|---|
| Arthur B. Landry | John R. Paul |
| Eugene F. Meschter | William H. Ryder |
| Robert W. Kaschub | John N. Gallivan |
| Martin I. Hall | James H. Biram |
| Cole B. Gibson | Walter N. Nelson |
| Paul W. Vestal | Ellwood Weise |
| Albert S. Gray | Gerard M. Chartier |
| Andrew J. Jackson | Philip J. Moorad |
| C. John Satti | Crit Pharris |
| Robert P. Knapp | Frank L. Polito |

Frank T. Oberg

The year just completed has been one of progress for this Committee. There were eight regular scheduled meetings and eighteen subcommittee meetings.

During the past year, both industry and labor have become more interested than ever before in occupational health. This interest was primarily due to the demands for increased production by the armed forces, in face of an already serious manpower shortage. Whereas, industries in general,

were meeting their production quotas a year ago, the armed forces during this past year suddenly found that production was waning, as a result of the rapid strides made by the allied armies. We are told that the advances were far beyond the expectations of the experts. More people had to be employed. Many had never before worked in industry, such as, housewives, clerks, farmers, salesmen, storekeepers, et cetera. In addition, there was an increase in shifting populations; and housing and transportation became more difficult. Industry was faced with an acute shortage of certain raw materials which necessitated the use of substitutes, some of which little or nothing was known regarding their effects on the health of the worker. Also, during the past year, industries in Connecticut have reabsorbed thousands of returning veterans, many of whom had to be retrained and rehabilitated. This was a difficult problem for the reason that many of the legal aspects needed interpretation and clarification. Finally, the armed forces were demanding and taking more nurses, including those already employed in essential industries. All of the above problems and many others too numerous to mention have either directly or indirectly been referred to this Committee for their advice and assistance during the past year.

The most outstanding accomplishment of the year was the joint Industrial Health Conference with the State Manufacturers Association, held in New Haven, December 14, 1944. Upwards of 350 attended the sessions. The program was designed to bring out all aspects of the returning veteran into industry, although many phases of present day occupational medicine were covered. This was the second joint meeting with the Manufacturers Association, the first one on May 7, 1942. The meeting was a huge success, and it was suggested by many of those who attended that meetings of this type should be held annually.

Early in the year the Committee was requested to develop a procedure which could be used as a guide by industry controlling the employment of pregnant women. After several meetings with a committee of obstetricians, a plan was submitted to the Manufacturers Association, setting forth guiding principles for the employment of pregnant women. This was later published by the Manufacturers Association and The Connecticut State Medical Journal.

This Committee has assisted in the development of Industrial Nursing courses and lectures at the University of Connecticut in Hartford, and at the St. Mary's Hospital School of Nursing in Waterbury. Many of the members of this Committee prepared and gave the lectures. Those given at the University of Connecticut, were post graduate courses. Both were huge successes and both plan to continue them this coming year.

During the past year this Committee has received numerous requests from industry to help them develop or expand their plant medical facilities. In order to do this, surveys were made at the plant, following which specific recommendations were submitted.

The Committee was requested by the State Secretary to study and comment on a Bill #361, An Act Concerning Trained Attendants. After careful consideration the Committee unanimously voted opposition to it.

At the request of the Council of the State Medical Society, this Committee studied a report of the Committee on Workman's Compensation Laws of the New London County Medical Association, and after careful consideration and a comparison with a similar report submitted by Dr. D. Chester Brown in 1935, the Committee declined to endorse some of the recommendations.

The Committee has prepared or procured articles for publication in the State Medical Journal throughout the past year. In addition the Committee has also provided speakers for both medical and lay groups on the subject of Industrial Medicine.

The Committee has had the pleasure of working with the Yale University School of Medicine in the development of a plan to broaden the teaching and research facilities of Industrial and Occupational Medicine. In addition, the Committee has studied the development and expansion of undergraduate and postgraduate courses in Industrial Medicine in medical schools throughout the country.

I would like to express my deepest appreciation to all members of the Industrial Health Committee for their splendid work during the past year. Their untiring efforts and enthusiasm have been responsible for making it successful. The Committee wishes to express its sincere thanks to the members of the Connecticut State Medical Society, the State Department of Health, State Department of Education, The Manufacturers Association, State Bureau of Rehabilitation, the Yale University School of Medicine, and all other agencies and individuals who have been so helpful.

Respectfully submitted,
C. F. Yeager

## REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

C. C. Burlingame, Hartford, *Chairman*
Barnett Greenhouse, New Haven
Mario L. Palmieri, Middletown
Donald M. Beckwith, Rockville
R. Harold Lockhart, Bridgeport
Elinor F. Downs, Litchfield
William H. Weidman, Uncas-on-Thames
William M. Shepard, Putnam

The Chairman of your Committee assumes full responsibility for its inactivity during the past year. The limitations of time and the pressure of work on all medical men in the state have made it seem impractical to call Committee meetings for the purpose of developing a broad public relations program. With the end of the war in sight, however, the reorganization of the Committee in order to increase its efficacy and its usefulness to the State Medical Society assumes growing importance. Suggestions for this reorganization are herewith presented.

The Committee on Public Relations according to present practice comprises representatives from the component county associations and a chairman. These members, selected to some extent on the basis of interest in publicity, have been well chosen but have delegated the actual operation of the publicity program to the Executive Offices of the Society. This follows the pattern of many organizations which are extending their public relations activities, in that the

public relations committees serve as policy-making bodies and do not perform actual publicity duties. Public relations or public education of any kind presuppose intimate and authoritative knowledge of the subject with which they deal. It appears, therefore, that the development of a broad, sustained public relations program for the Society calls for representation on the Committee of the various fields of medical knowledge and skill.

A study of the organizations which have been most successful in public relations indicates that there should be a sharp differentiation between propaganda and advertising on the one hand, and the development of policies on the other hand. It would seem that your Public Relations Committee should devote itself primarily to the second, i.e. to the development of policies, for it is in this field that the greatest need obtains. In the matter of mechanics of the execution of policies, a beginning has already been made in the Executive Offices of the State Society and considerable active work has been accomplished in the past twelve months.

It is suggested, therefore, that consideration be given to the reorganization of the Committee on Public Relations on an ex-officio basis, in order that the sources, the material and the interpretation of the objectives and the policies of the various committees of the Society may be coordinated in a broad, cohesive public relations policy. To this end, representatives from the following committees might be included in the makeup of the Committee on Public Relations: (a) Committee on Public Health, (b) Committee on Industrial Health, (c) Committee on Tumor Study and certain other committees to be determined by the Council. A representative of the Council and the Executive Secretary of the Society might be added to the committee as ex-officio members. It is further suggested that, in order to benefit by authoritative, specialized knowledge, representatives of certain specialties such as (a) psychiatry, (b) rehabilitation, (c) pediatrics, (d) veterans' affairs, (e) geriatrics, might well be added. Such a group, meeting with the Chairman as coordinator, would be in a position to formulate strong policies for the authoritative interpretation to the public of medicine and medical affairs. It would be equipped to devise methods and procedures for furthering its policies and it would by its constitution be properly representative of the membership and general interests of the Society.

Respectfully submitted,
C. Charles Burlingame

## REPORT OF THE DRUG ADDICTION COMMITTEE

John H. Foster, *Chairman*

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| C. Charles Burlingame | Alfred Labensky |
| A. Bliss Dayton | Chester Waterman |

Drug addiction is still a problem in this state as is shown by the yearly increase in the number of cases handled by the Narcotic Bureau of the State Department of Health. Following the war all indications point to an even greater increase.

The oriental smuggling rings, for the present only, are suppressed because of the war blockade.

Paregoric is one substitute being used by addicts and is becoming an increasing problem. A bill to restrict the sale of paregoric to a physician's prescription was submitted again to the present legislature, but was defeated.

Demerol has been added to the list of narcotic drugs covered by the Uniform Narcotic Act.

The barbiturates are being recognized as the major drug problem of the day. They are perhaps the most widely used drugs in practice today and one of the most valuable. However, it is felt by many that the present laxity in control of sales is responsible for a great increase in barbiturate addicts resulting in an estimated 1-2 deaths weekly in the state from over dosage, and 2-3 commitments to institutions for addiction. It is felt that more restrictions in the sale and in the refilling of prescriptions should be made.

Respectfully submitted,
John H. Foster

## REPORT OF THE CONFERENCE COMMITTEE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

Stanley B. Weld, *Chairman*

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| William J. H. Fischer | Barnett Greenhouse |
| John H. Foster | Walter I. Russell |

Mr. President and Members of the House of Delegates:

Again the Conference Committee with the State Pharmaceutical Association has held no meetings during the past year. Only recently members of this committee have been asked to lend their support to defeating Substitute for House Bills 592 and 593 which would lower the standards heretofore approved for licensing pharmacists in Connecticut. This has been done by appearance at the hearing on the bill, by some editorial writing and by securing conferences with Representatives in the General Assembly.

Respectfully submitted,
Stanley B. Weld

## REPORT OF THE ADVISORY COMMITTEE TO THE PUBLIC WELFARE COUNCIL

James R. Miller, *Chairman*

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| Wilmar M. Allen | Eugen Kahn |
| Creighton Barker | George M. Smith |
| H. Gildersleeve Jarvis | Charles H. Sprague |

This committee was appointed to make technical advice in the field of medical care available to Dr. Heiser in the study which he was making for the Public Welfare Council on the Need for a State Infirmary for the Care and Treatment of Aged, Infirm, and Chronically Ill Persons which was authorized by Number 470 of the Special Acts of 1943. This committee acted as medical advisors particularly in defining chronic illness as "A disease or condition of the body or personality which has been present at least six months or which may be expected to continue at least six months and which interferes with one's occupation and

normal physical and social life." Advice was given during the onset of the study in outlining those avenues which appeared to be most worthy of exploration and toward the end of the study advice was given concerning the meaning of some of the results which were to be deduced from the study of the tables. Members of the Society are urged to become acquainted with this report as it contains a mass of valuable information even though one does not have to agree with the program which is recommended. At the time of writing this report it has become evident at the public hearing on S. B. 144 that there is wide spread interest in better provision for the chronically ill.

Respectfully submitted,
James R. Miller

## REPORT OF THE ADVISORY COMMITTEE TO THE PUBLIC WELFARE COUNCIL ON FEDERAL FUNDS

James R. Miller, *Chairman*
Theodore S. Evans — David Gaberman
Chris H. Neuswanger — Alfred Labensky
D. C. Y. Moore

Your Committee has endeavored to bring to the Public Welfare Council technical assistance in developing the program of payment for medical care under public assistance acts controlled by the Commission of Public Welfare. As soon as these recommendations have been confirmed by the Department of Welfare they have been published in the JOURNAL.

Respectfully submitted,
James R. Miller

## REPORT OF THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

James R. Miller, *Chairman*
Creighton Barker — Thomas P. Murdock

It would be repetitious at this time to report on the transactions of the House of Delegates of the American Medical Association for 1944 since these have been published verbatim in the *Journal* of the American Medical Association, and, in fact, comments on the meeting of the House of Delegates have been extensively summarized in THE CONNECTICUT STATE MEDICAL JOURNAL.

Your Delegates were successful in securing the adoption by the House of Delegates of a resolution commemorating the services of Horace Wells of Hartford, Connecticut, in discovering nitrous oxide as an anesthetic. This resolution came in time to be incorporated with the records of the celebration in Hartford of the 100th Anniversary of the discovery.

At the time of writing no date has been set for the meeting of the House of Delegates in 1945 though it is expected that a meeting will be allowed and that it probably will be in Chicago.

Respectfully submitted,
James R. Miller

## REPORT OF THE SPECIAL COMMITTEE TO STUDY PROFESSIONAL LIABILITY INSURANCE

Louis F. Wheatley, New Haven, *Chairman*
Benedict B. Landry, Hartford
John F. O'Brien, Waterford
Charles W. Goff, Hartford
R. Harold Lockhart, Bridgeport

The Committee appointed at the Annual Meeting of the House of Delegates of the Connecticut State Medical Society May 8, 1944 to study Professional Liability Insurance in Connecticut, particularly the group contracts that are written for Connecticut physicians by the Aetna Life Insurance Company, has held one meeting early in December, 1944. Previous to this meeting preliminary study was made of the entire Insurance problem as it affects Connecticut physicians, and data assembled for presentation to this Committee. The entire subject was discussed at length and after full consideration the Committee unanimously recommended that the Connecticut State Medical Society accept the proposition submitted by the Aetna Life Insurance Company which is as follows:

That a Connecticut State Medical Society Group Professional Plan be established and that it be in a form of either one group policy for the entire State or separate group policies for each county unit. The State Group Plan would automatically include every component County Medical Association. The minimum basic premium rate would be $12.50 for a coverage of $10,000–$25,000. This would be graded upward according to the limits of coverage up to $24.00 for $75,000–$150,000. Higher limits would also be available.

All members in good standing from all county units and of the State Medical Society would be eligible for this protection, also anyone who has application for membersihp on file with his County Association.

This recommendation was accepted and adopted by the House of Delegates at their meeting on December 8, 1944 and became effective February 1, 1945. By this action our members will all be united under one State Group Plan that will embrace the entire State of Connecticut, thus bringing the group plan home to the members of two of our component County Medical Associations who have nothitherto had any group protection available to them. The low rate of $12.50 for basic coverage of $10,000–$25,000 will now be available to all members subscribing to the State Group Plan, a service which has not been available to some members in the past.

As a result of a situation developing in the New Haven Medical Society last year in which a physician was sued for breach of "verbal contract," a new agreement was made with the Aetna Life Insurance Company whereby a statement was inserted in the Master Group Policy to the effect that our members would be afforded coverage for every contingency which might arise from which the Association or its members might be held liable as respects the rendering of professional services by any insured doctor, subject to the general exclusions as respects written guarantee of result; criminal acts, acts committed while under the influ-

ence of intoxicants or narcotics; or because of partnership, hospital, or other business enterprise.

This broadened coverage has been incorporated in the Connecticut State Group Plan.

Respectfully submitted,
Louis F. Wheatley.

## REPORT OF THE COMMITTEE ON BY-LAW REVISION

William M. Shepard, *Chairman*
Charles G. Barnum Cole B. Gibson
Thacher W. Worthen

This committee submitted the revision of the by-laws of the Society to the Council for consideration. The report of the committee was referred to a special committee from the Council consisting of Arthur B. Landry, chairman; George H. Gildersleeve and Herbert Thoms. Dr. Landry's committee reviewed the report of the Special Committee and presented all of the proposed changes to the Council for review.

The Council recommends for adoption new by-laws for the Society.

## CONNECTICUT STATE MEDICAL SOCIETY REVISED BY-LAWS

### ARTICLE I
NAME

*Section 1. Name*

Par. 1. The name of this organization shall be The Connecticut State Medical Society.

### ARTICLE II
PURPOSES

*Section 1. Purposes*

Par. 1. The purpose of this Society shall be to federate and bring into one organization the medical profession of the State of Connecticut; to unite with similar societies in other states to form the American Medical Association; to extend medical knowledge and advance medical seience, to elevate the standard of medical education, and to promote friendly intercourse among physicians, to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never be maintained and conducted for the pecuniary profit of its members, officers, or employees but shall be, and remain, a strictly scientific and educational corporation, and no member, officer or employee of the Society shall at any time receive or be entitled to receive any pecuniary profit from the operation of the Society except a reasonable compensation for services actually rendered.

### ARTICLE III
ETHICS

*Section 1. Ethics*

Par. 1. The Principles of Medical Ethics of the American Medical Assoication shall govern the conduct of members in their relations to each other and to the public.

### ARTICLE IV
COMPONENT ASSOCIATIONS

*Section 1. Component Associations*

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

### ARTICLE V
MEMBERSHIP

*Section 1. Membership*

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

*Section 2. Members*

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

*Section 3. Student Members*

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 478f of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of the Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Soeiety on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

*Section 4. Associate Members*

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that

they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

*Section 5. Honorary Members*

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 5. They shall be accorded the privilege of participating in scientific work.

## ARTICLE VI

### Officers

*Section 1. Officers*

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Editor-in-Chief of the Journal, the elected Delegates to the American Medical Association, and eight Councillors.

Par. 2. The officers, except the President and the Councillors, shall be nominated by the Council and elected annually by ballot of the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham and Middlesex counties in the odd years.

Par. 5. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even years.

Par. 6. Any vacancy in the office of Councillor shall be filled by the county association in which the vacancy occurs.

*Section 2. Duties of Officers*

Par. 1. The President shall preside at meetings of the Society and at meetings of the House of Delegates, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties, preside at meetings in the absence of the President, or on his request. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the unexpired term by the First Vice-President and he will be succeeded by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the Journal prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or, in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Editor-in-Chief of the Journal, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the Journal by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

## ARTICLE VII

### Meetings

*Section 1. Annual Meetings*

Par. 1. The Society shall hold an Annual Session during which there shall be held Scientific Meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

*Section 2. Special Meetings*

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

*Section 3. Recommendations*

Par. 1. Recommendations made by any Scientific Session or Section Meeting may be submitted to the House of Delegates.

## ARTICLE VIII

### House of Delegates

*Section 1. House of Delegates*

Par. 1. The House of Delegates shall be the legislative

and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist of the delegates elected by the component county associations and the members of the Council.

Par. 2. Each component association shall be entitled to send to the House of Delegates each year one delegate for every thirty-five members or any additional part of that number. A component county association with less than thirty-five members shall be entitled to one elected member of the House of Delegates.

*Section 2. Duties*

Par. 1. The House of Delegates shall elect Delegates and Alternate Delegates from the Society to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body. These Delegates and Alternates shall take office on the first of January following their election and shall serve terms of two years.

Par. 2. The House of Delegates shall have authority to appoint committees for special purposes from among the members of the Society. Such committees shall make written report through the Council to the House of Delegates, and members of these committees may attend meetings of the House of Delegates and participate in the discussion of reports submitted by them.

Par. 3. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections.

Par. 4. No memorial or resolution shall be issued in the name of the Society without first having been approved by the House of Delegates.

*Section 3. Meetings*

Par. 1. The Annual Meeting of the House of Delegates shall be called by the Council and shall be held during the week of the Annual Session of the Society. The order of business shall be arranged as a separate section of the program by the Council. The President of the Society shall preside at all meetings or designate one of the Vice-Presidents to preside in his absence.

Par. 2. A Semi-Annual Meeting shall be held when required at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quorum.

## ARTICLE IX

### The Council

*Section 1. Membership*

Par. 1. The Council shall consist of one Councillor from each County and the President, the President-Elect, the Executive Secretary, the Treasurer, the Editor-in-Chief of the Journal and the Delegates to the American Medical Association. Seven members of the Council shall constitute a quorum for the transaction of business.

*Section 2. Meetings*

Par. 1. The Council shall meet at least once in two months throughout the year, except during the months of July, August and September, and at such other times as it may be called by the Chairman of the Council or upon petition of three members of the Council. It shall have its Annual Meeting for the purpose of organizing and the election of a chairman at its first meeting following the Annual Meeting of the House of Delegates.

*Section 3. Duties*

Par. 1. The Council shall have the power to act for the House of Delegates between meetings of that body and shall report such action to the House of Delegates at its next meeting.

Par. 2. The Council shall be the Nominating Committee of the Society and it shall report as such to the first session of the Annual Meeting of the House of Delegates. After the report has been made an opportunity shall be given for other nominations to be made.

Par. 3. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken, and its decision in all such matters shall be final.

Par. 4. The Council shall serve as a Board of Review for cases of claimed malpractice referred to it by the Committee on Medical Ethics and Deportment of any component County Association.

Par. 5. The Council shall be the Finance Committee of the Society and shall superintend and direct all financial transactions of the Society and shall prepare and submit annually to the House of Delegates a budget for the operation of the Society.

Par. 6. The Council shall make an Annual Report to the House of Delegates.

## ARTICLE X

### Committees

*Section 1. Standing Committees*

Par. 1. The Standing Committees of the Society shall be as follows:

A Committee on Arrangements.
A Committee on the Clinical Congress.
An Editorial Board of the Journal.
A Committee on Honorary Members and Degrees.
A Committee on Hospitals.
A Committee on Industrial Health.
A Committee on Medical Education and Licensure.
A Program Committee.
A Committee on Public Health.
A Committee on Public Policy and Legislation.
A Committee on Public Relations.
A Committee on Tumor Study.

Par. 2. Unless otherwise specified in these by-laws, nominations for these committees and their chairmen shall be made by the Council and presented to the Annual Meeting of the House of Delegates.

Par. 3. All standing committees except the Committee on Arrangements shall make annual written reports to the Council before the first of April of each year for transmittal with recommendations to the Annual Meeting of the House of Delegates.

*Section 2. Special Committees*

Par. 1. Special Committees may be appointed by the Council or elected by the House of Delegates as may from time to time be required. Committees appointed by the Council shall make written reports to the Council as directed by it. Committees elected by the House of Delegates shall make written reports to the Council in the same manner as provided for standing committees.

*Section 3. Duties of Committees*

Par. 1. The Committee on Arrangements shall be appointed by the component association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting places of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

Par. 2. The Council shall nominate to the House of Delegates each year a Committee on the Clinical Congress, and its Chairman, a Secretary and a Treasurer. The function of the committee shall be the arrangement and direction of the annual Clinical Congress of the Society and such other activities in postgraduate instruction as may from time to time appear desirable to the committee. The Chairman, the Secretary and the Treasurer shall be the trustees of the funds of the Clinical Congress, and this Committee, through its Treasurer, shall receive income from registration fees of the Congress and other sources of income incident to the administration of the Congress, and pay therefrom all necessary expenses. This fund shall be audited by the Society's auditors and a report of the transactions of the fund for the fiscal year shall be rendered by the Treasurer of the Clinical Congress to the House of Delegates each year at its Annual Meeting. The Treasurer of the Clinical Congress shall give bond in a sum and manner of bonding prescribed by the Council. He shall remit to the general fund of the Society such part of the funds of the Clinical Congress as the Council from time to time may direct.

Par. 3. The Council shall nominate to the House of Delegates each year an Editorial Board for the JOURNAL consisting of five members, and nominate the Chairman of the Board who shall serve as Editor-in-Chief of the JOURNAL. The Editor-in-Chief shall be a member of the Council. In addition to the Board so nominated, the President of the Society shall serve as an ex-officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the CONNECTICUT STATE MEDICAL JOURNAL and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Council shall nominate annually to the House of Delegates a Committee on Hospitals to consist of not less than six members, and shall nominate the Chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Council shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry. This committee shall also represent the Society in all matters pertaining to the operation of the Workmen's Compensation Law.

Par. 7. At each annual meeting the Council shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Council for election by the House of Delegates for a term of three years. The Chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the meetings of the

Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Par. 9. The Council shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration desirable legal enactments to promote public health within the State.

Par. 10. The Council shall nominate to the House of Delegates annually a Committee on Public Policy and Legislation not to exceed fifteen members and nominate the Chairman thereof. The Committee shall include one representative from each of the eight component county associations of the Society and the Delegates from this Society to the American Medical Association. The Executive Secretary of the Society shall be a member of this Committee and serve as its executive officer. The function of this Committee shall be to review and advise the members of the Society concerning proposed state and national legislation pertaining to the public health, welfare and the practice of medicine. It shall, as occasion arises, draft and have introduced into the General Assembly of this State appropriate legislation for improving medical care and the public health within the State, advise the Society's legislative agent concerning the opinion of the Society on pending legislation and supervise and direct the Society's program in the legislative field.

Par. 11. The Council shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio. and cooperate with other committees of the Society in a program of public relations.

Par. 12. The Council shall nominate to the House of Delegates annually a Committee on Tumor Study of not less than fifteen members and nominate the Chairman thereof. The function of this Committee shall be a continuing study of the problem of malignant disease within the state, to inform the members of the Society concerning developments in this field, to encourage and increase accuracy in the recognition and treatment of malignant tumors, to cooperate with the Connecticut State Department of Health and other public and private agencies in the establishment and maintenance of diagnostic tumor clinics for service to indigent persons within the state, and as occasion arises make recommendations to the Society concerning legislation in this field.

## ARTICLE XI

### Funds and Expenses

#### *Section 1. Funds*

Par. 1. Funds for the operation of the Society shall be raised by an equal annual per capita assessment from each member of a component county association, except:

Par. 2. Members who are elected to the county associations at the semi-annual meetings will be assessed one half of the annual dues for the year of their election.

Par. 3. Members who have been in good standing in the Society for forty consecutive years or who have attained the age of sixty-eight and shall have been members of the Society for fifteen years immediately preceding, shall, upon written request addressed to the Treasurer of the Society, be exempt from further payment of dues and shall continue as active members of the Society enjoying all rights and privileges.

Par. 4. The dues of any member may be remitted by a majority vote of the House of Delegates.

Par. 5. All funds of the Society shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on January 1 and terminate on December 31 of each year.

#### *Section 2. Budget*

Par. 1. The annual budget of the Society shall be prepared by the Council, as the Finance Committee of the Society, and be presented to the House of Delegates for approval. Based upon that budget the Council shall recommend to the House of Delegates the amount of per capita assessment for the ensuing fiscal year. All requests and resolutions appropriating funds of the Society shall be referred to the Council for recommendation to the House of Delegates and all such requests and recommendations must be approved by the House of Delegates before funds may be expended.

#### *Section 3. Fidelity Bonds*

Par. 1. The Council shall prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society.

## ARTICLE XII

### Referendum

#### *Section 1. Referendum*

Par. 1. A General Meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds

vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

## ARTICLE XIII

### Component County Associations

*Section 1. Component County Associations*

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham Counties now in operation and in affiliation with The Connecticut State Medical Society shall be the component county associations of this Society.

*Section 2. Function*

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1 of these By-Laws.

*Section 3. Eligibility for Membership*

Par. 1. All registered physicians licensed under Article 2747 of the General Statutes of the State of Connecticut, 1930, as amended, who have resided and practiced under that license in the State of Connecticut for one year shall be eligible to apply for membership.

*Section 4. Application for Membership*

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

*Section 5. Transfer of Membership*

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credential Committee of the component association in this State in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association without regard to the residence requirement prescribed in Section 3 of this Article.

*Section 6. Membership Roster*

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name, address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

*Section 7. Discipline*

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this decision shall be final.

*Section 8. Termination of Membership*

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

*Section 9. Delegates to the House of Delegates of the Society*

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any additional part of that number. The component association with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the Annual Meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate

delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the State Society of the appointment at once and before the alternate delegate may be seated in the House of Delegates.

*Section 10. Dues*

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1st of each year and the component county associations shall forward all monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January of each year.

*Section 11. By-Laws*

Par. 1. The component county associations shall have the power to adopt only such By-Laws as are not in conflict with the By-Laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the By-Laws of the Society shall take precedence over those of a component county association.

ARTICLE XIV

AMENDMENTS

*Section 1. Amendments*

Par. 1. The By-Laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the By-Laws shall be submitted first to the Council and published, with the Councils recommendation, in THE CONNECTICUT STATE MEDICAL JOURNAL at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates in the notices of the meeting at which the amendments are to be acted upon.

ARTICLE XV

PARLIAMENTARY PROCEDURE

*Section 1. Rules of Order*

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Roberts Rules of Order.

*Section 2. Enablement Clause*

Par. 1. The adoption of these By-Laws rescinds and revokes all previous By-Laws of the Society and supercedes their operation.

## Ascorbic Acid in Orange Juice

Rohrer and Treadwell, in *Texas Reports on Biology and Medicine*, Volume 2, Number 2 (1944), report on the content and stability of ascorbic acid in orange juice under home conditions. Their conclusions are as follows:

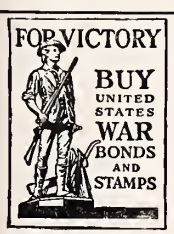
1. The method of squeezing or extracting orange juice and storage in the refrigerator either in an open or in a closed container, has no significant effect on the ascorbic acid content of strained or unstrained juice over a 24 hour period.

2. Dilution of the orange juice one-third with tap water before refrigeration does not hasten the destruction of ascorbic acid.

3. There is little effect on the ascorbic acid content of orange juice when stored at room temperature for 24 hours, and no effect when maintained at 100° F. for ten minutes.

4. The cut half of an orange may be stored in the refrigerator until the following day without serious loss of ascorbic acid.

5. An intake of two and five ounces of fresh orange juice per day in infant and adult, respectively, will supply recommended daily amounts of vitamin C: i.e., 30 and 75 mg., respectively.




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(SEE PAGE 2)

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. H. Bertram Lambert, Bridgeport
*Vice President*, Mrs. Creighton Barker, New Haven
*Secretary*, Mrs. Charles W. Goff, West Hartford
*Treasurer*, Mrs. Julian G. Ely, Lyme

### Board of Directors Meeting

A special meeting of the Board of Directors was held on March 15, at the Hunt Memorial Building in Hartford. Mrs. Douglas O. Burnham, chairman of the Field Army on Cancer Program in Connecticut, addressed the meeting, explaining new plans in this work. The Board also attended to various business matters.

### New Haven County Auxiliary Organizes

The organizational meeting of the New Haven County Woman's Auxiliary was held at the New Haven Medical Association Building on March 8. The following officers were elected: President, Mrs. Luther Musselman; Vice-President, Mrs. Eugene Blake; Second Vice-President, Mrs. Simon B. Kleiner; Recording Secretary, Mrs. Paul W. Vestal; Corresponding Secretary, Mrs. Frank DiStasio, all of New Haven; and Treasurer, Mrs. Joseph W. Hetzel, Waterbury.

Dr. James R. Miller of Hartford addressed the meeting on the subject, "Objectives of the Auxiliary." He stressed the education of physicians' wives in state, federal and local health programs, the promotion of good fellowship between physicians' families and the assistance the Auxiliary can render the County Association when it acquires its new building after the war. Dr. Miller gave as an example of educational aims the broadening of our knowledge of present and proposed medical legislation.

### Organization of Windham County Auxiliary

On Friday, April 6, a small group of physicians' wives of Windham County met at the Pomfret Inn in Pomfret, for the purpose of forming an Auxiliary to the Windham County Medical Association. A resolution to this effect was unanimously passed.

Mrs. H. Bertram Lambert of Southport, president of the State Auxiliary, and Mrs. Creighton Barker of New Haven, vice-president of the State Auxiliary, attended the meeting and spoke on the history of the Auxiliary, its formation, aims and problems.

Dr. George H. Carter of Willimantic welcomed the group on behalf of the State and County Medical Societies and spoke of the help the Auxiliary can render to them.

The following slate of officers was presented by the nominating committee and the secretary of the meeting was empowered to cast one ballot in favor of the slate as presented by the committee: President, Mrs. Ralph Gilman, Storrs; Vice-President, Mrs. Andrew Laakso, Danielson; Secretary, Mrs. George H. Carter, Willimantic; and Treasurer, Mrs. David Bates, Woodstock.

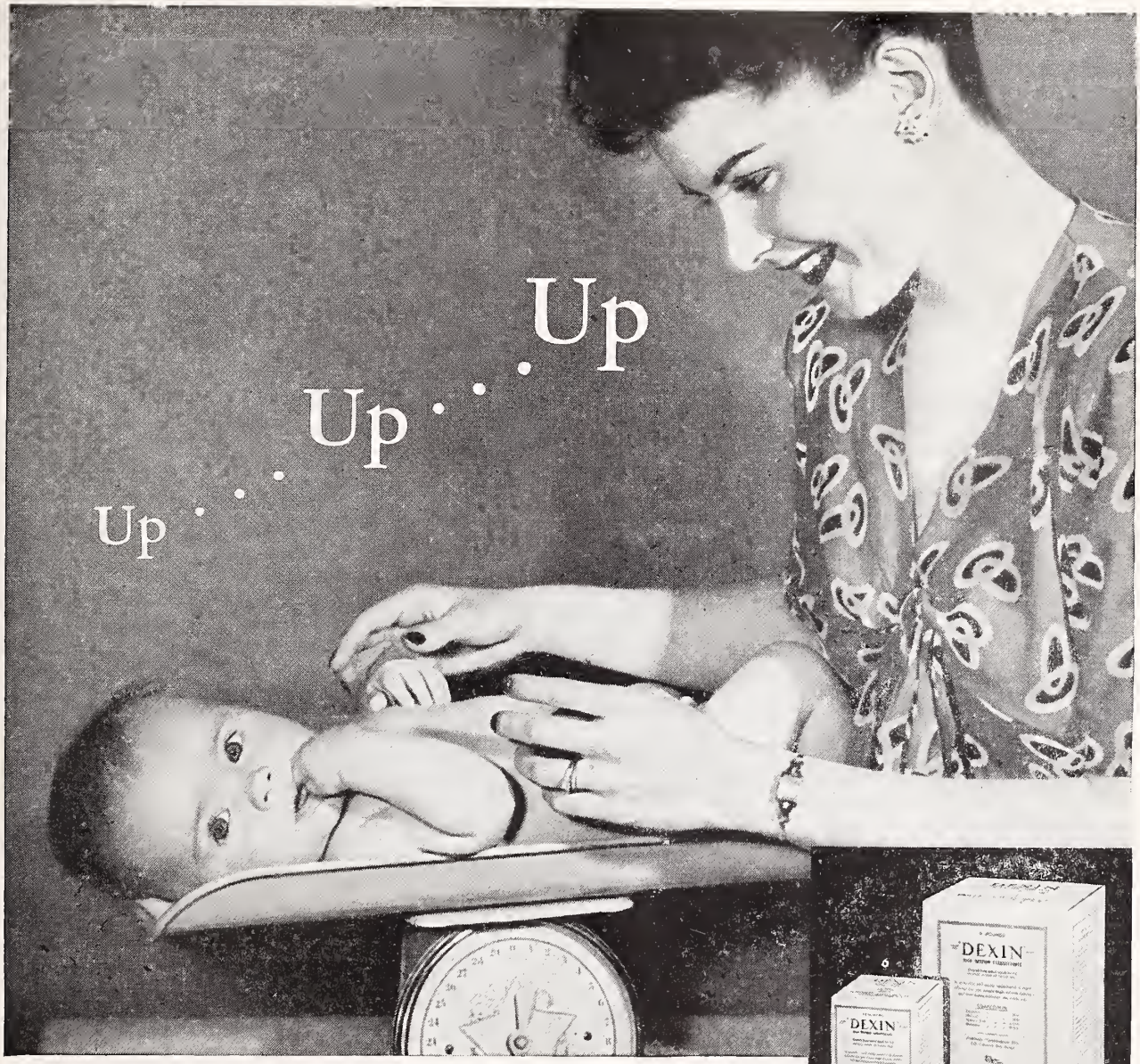
The following committee chairmen were appointed: Legislation, Mrs. William Mac Shepard, Putnam; War Participation, Mrs. Andrew Laakso, Danielson; Hygeia, Mrs. Richard Shea, Willimantic; Constitution, Mrs. Kenneth Kinney, Mansfield.

Tea was served and the meeting was adjourned.

At the meeting, Mrs. Edward Ottenheimer of Windham Center presided as chairman and Mrs. George H. Carter of Willimantic acted as temporary secretary.

### Annual Meeting of Hartford County Auxiliary

The first annual meeting of the Woman's Auxiliary to the Hartford County Medical Association was held at the Hartford Club on April 3. The business meeting was opened at 4 P. M. by Mrs. Arthur Landry, president, who presented Mrs. H. B. Lambert, state president, to the assembled group. Mrs. Lambert announced that the meeting of the State Auxiliary would be held in New Haven on May 23. Mrs. Creighton Barker gave a report on the good progress of the organizational work in the other counties in Connecticut. The Constitution and By-Laws of the Hartford County Auxiliary were adopted as presented by Mrs. F. D. Ellis, Jr. The reports which were given by the chairmen of




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*Literature on request*




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COMPOSITION

| | |
|---|---|
| Dextrins | 75% |
| Maltose | 24% |
| Mineral Ash | 0.25% |
| Moisture | 0.75% |

Available carbohydrate 99%
115 calories per ounce
6 level packed tablespoonfuls equal 1 ounce
Containers of 12 oz. and 3 lbs.

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all the standing committees evidenced that much progress has been made by this young organization in its various fields of endeavor.

The following new officers were elected: President-elect, Mrs. Paul Phelps, Canton; Second Vice-President, Mrs. Stanley H. Osborn, West Hartford; Corresponding Secretary, Mrs. E. M. Andrews, West Hartford.

Following the business meeting Dr. James R. Miller gave a very interesting talk on the legislative problems confronting the medical profession. He discussed state and national bills which the legislatures are considering and explained their values and deficiencies. Dinner was served at 7 P. M. Following the dinner, Mrs. Louis Spekter of Hartford, one of the members of the organization, delighted her audience with a group of songs. Mrs. Stanley Osborn, chairman of the program committee, presented the evening speakers. Dr. Creighton Barker spoke about the difficulties encountered in extending medical man power so that Connecticut might supply its share of physicians to the services and still give adequate service to civilians. He said that Connecticut has fulfilled its obligations to the armed forces and still has one physician to less than 1,200 civilians. Dr. Alfred Burgdoff discussed the problems confronting the health officer in wartime. He stated that one of the dangers to public health is tropical diseases which might be brought back by returning servicemen, and discussed ways of dealing with the threat of malaria as an example. Mrs. Helen Cullen presented the problems of the nursing profession in wartime and said that, in spite of the excellent response of the nursing profession, more nurses are needed in the armed forces because of the increased fighting tempo on all fronts. Col. T. R. Preston, chief medical officer, Veterans Administration, Newington, gave an interesting and informative talk on the medical services available to veterans and army personnel on furlough. He said that the present veteran is getting excellent medical care. An interesting discussion followed, participated in by many of the members present.

## ANNUAL REPORTS

### REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Ralph L. Gilman, *Chairman*

| | |
|---|---|
| Alfred Labensky | Jessie W. Fisher |
| John D. Booth | Cole B. Gibson |
| Martha L. Clifford | E. Myles Standish |

This committee was elected to serve as an advisory body to the Woman's Auxiliary whenever called upon by that organization. The committee has held no meeting this year because the Woman's Auxiliary has presented no matters to it for its consideration. It has been the feeling of the chairman that the committee should not participate in any matters purely of internal administration of the organization. Since these matters have been the ones which have occupied their time during the current year, it is not particularly surprising that they have not called upon the committee for any advice.

Respectfully submitted,
Ralph L. Gilman

### REPORT OF COMMITTEE ON REVISION OF THE CONSTITUTION AND BY-LAWS

Mrs. Paul S. Phelps, *Chairman*, Canton
Mrs. H. Bertram Lambert, ex-officio, Southport
Mrs. F. D. Ellis, Farmington
Mrs. George Buckhout, Bridgeport
Mrs. Harold Wellington, New London
Mrs. Frederic Tracy, Middletown

Due to the fact that all County Auxiliaries have not been organized, the above committee is not complete.

A meeting of this committee has been called for April 18 at which time the members will discuss revisions to be presented to the Board of Directors.

Madeline E. Phelps

### REPORT OF WAR PARTICIPATION COMMITTEE

The appointment of the State Chairman of the War Participation Committee was made by the president, Mrs. Lambert, in November, 1944. Since then three members have been added to the committee: Mrs. Stanley B. Weld of Hartford, Mrs. William J. Logan of New Haven and Mrs. Louis Soreff of East Hampton. The committee is now working on a news letter to be sent to the physicians in service. It is the second of this kind to be sent from the Auxiliary, the first having been a Christmas letter to which there has been an enthusiastic response from many physicians far from home.

Respectfully submitted,
Mrs. Frank Stafford Jones, *Chairman*

### REPORT OF HYGEIA COMMITTEE

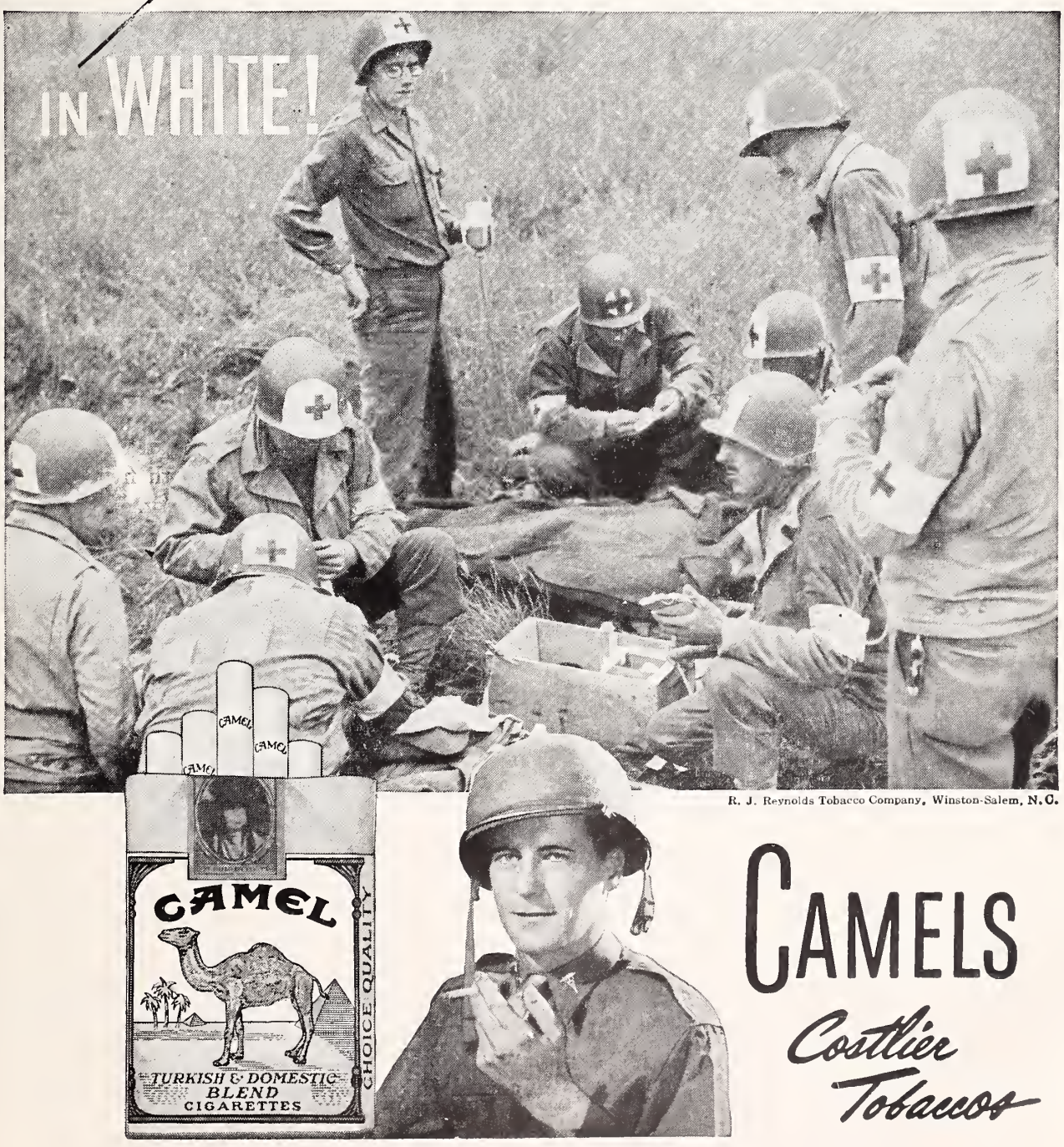
Madam President and Members of
The Connecticut State Medical Auxiliary:

Soon after appointment to office of a State Hygeia Chairman new subscriptions to *Hygeia, The Health Magazine* were suspended because of the paper shortage. To date no county auxiliary, with the exception of Hartford County, has appointed a Hygeia chairman. Therefore, except for an introductory report to the members of the Hartford County Medical Auxiliary on April 3, this chairmanship has been non functional.

Respectfully submitted,
Mrs. Dewey Katz

# Combat Team IN WHITE!

They're armed with tourniquets and plasma instead of guns and grenades. • They're the combat team of medical science—the medical officer and the aid men—and they're fighting men, through and through. • It isn't a showy fighting job—just hard, dangerous work that goes on even when the guns are quiet. So often, rest for the men of medicine is limited to a few moments of relaxation with a friendly cigarette. More than likely it's a Camel cigarette; for Camels, with their mildness and full, round flavor, are such a big favorite with fighting men in *all* the services.




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# CORRESPONDENCE

## The Oral Administration of Penicillin With Trisodium Citrate As a Buffer

To the Editor:

Following the suggestion by Charney, Alburn, and Bernhart and supplemented by the recent publication by Gyorgy, Vandegrift, Elias, Colio and others in Philadelphia, I have tried and found clinically successful the administration of the trisodium citrate with penicillin in liquid form.

Seven cases of bronchopneumonia, eleven cases of otitis media, two cases of non specific prostatitis and one case of pyelitis have benefited rapidly and cleared clinically within one to four days without any complications or side effects.

The general scheme is to give approximately one gram of trisodium citrate for every ten thousand units of penicillin in distilled water. This is taken orally every three hours around the clock. The solution for and adult dose is made up generally in a six ounce mixture containing eight grams of the trisodium citrate and one hundred thousand units of penicillin. All this is dissolved in six ounces of distilled water. The solution is apparently efficacious for twenty-four hours and should be kept in refrigeration.

Unfortunately the facilities are lacking in this locality for the blood and urine determination of penicillin concentrations. However so far, the clinical results seem to speak for themselves and at least it is worth a trial so as not to subject the patient to frequent intramuscular injections and the consequence of occasional local thromboplebitis.

As the Philadelphia observers suggest the use of soda bicarbonate and similar antacids are undesirable and impractical.

The amounts of penicillin and trisodium citrate of course may undergo modification depending upon future investigations.

In conclusion, penicillin given orally in conjunction with trisodium citrate was found to be clinically effective in several cases of bronchopneumonia, otitis media and other conditions. The effective dosage has not been completely worked out pending more investigation and chemical determination.

David L. Ellrich, M.D.,
Westport, Connecticut

## School Health Symposium Held In Greenwich

That the school teacher is the most important factor in a school health program was expounded by Dr. Dorothy B. Nyswander, U. S. Government health specialist and originator of the Astoria plan of physical examinations, at a health symposium arranged by the Board of Education at Greenwich High School on Wednesday afternoon and evening, March 7.

J. Frederick Close, chief physician of the Greenwich schools, also spoke. He reviewed the present health program in the schools and suggested a three point program which he hopes will be included soon in the Greenwich schools. This program would provide for the following:

1. An expanded program for tuberculosis examination. At present x-ray tests are given children of high school age through facilities of the Greenwich Tuberculosis & Health Association.

2. Establishment of a diagnostic clinic for rheumatic fever in cooperation with the Greenwich Tuberculosis & Health Association. Dr. Close said that this disease is the leading cause of death for children between the age of five and fourteen.

3. A program for posture correction through the use of silhouette photographs and corrective exercises.

The symposium was attended by school teachers, members of parent-teacher organizations and the public. It opened at 5 P. M. with five round table discussions on sanitation and safety, mental hygiene, physical education and health instruction, dental health and nutrition and health service.

Dinner was served in the High School Cafeteria at 7 P. M. followed by the open session at 8 P. M. at which Dr. Nyswander and Dr. Close were the principal speakers.

---

## Proposed Adoption Law and Procedures

Because no one adoption law in existence can be considered as a "model" to be followed by another State in its entirety, the Children's Bureau of the U. S. Department of Labor has drawn up a preliminary draft of "Essentials of Adoption and Procedures." This was prepared primarily for review by the Children's Bureau staff and legislative committees now at work in various States. The draft is confined to the adoption law as related to minors. It recognizes the fact that each State must take into consideration its own special needs and situations.



## *the important mild case*

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# SPECIAL NOTICES

## TEACHING GUIDE FOR HOME NURSE CLASSES

*Teaching Guides* to assist instructors of high school and college courses in Red Cross Home Nursing are now being prepared by the American Red Cross to be ready this fall. Providing specific suggestions for class discussions, demonstrations, and practice, the material is so arranged that the course may be adapted, with or without credit, to existing curricula. The course may be taught entirely by a nurse instructor or in cooperation with instructors of other courses in the same general field.

The high school guide will present simpler nursing procedures with specific methods of teaching them to adolescent students. The college guide will include these, but will be more extensive in scope, and through the inclusion of basic principles underlying procedures will be of higher academic level.

The war-time shortage of physicians and professional nurses has emphasized the urgency of more extensive home nursing instruction. As a result, many educators have become convinced that home nursing should be made an integral part of the education of all potential homemakers.

Many professional nurses are needed for part—or full time teaching, and through this teaching each instructor makes a valuable, far-reaching contribution to improved nursing care of the sick.

## CHEST PHYSICIANS CANCEL MEETING

The American College of Chest Physicians, with a membership in 23 countries, has cancelled its annual meeting scheduled to be held at Philadelphia, June, 1945.

The Executive Council of the College voted to hold a business meeting of the Board of Regents at Chicago, June 17.

## ANNOUNCE SALMON LECTURER

C. Charles Burlingame, chairman of the Salmon Memorial Committee, has announced the selection of Roy Graham Hoskins as the Salmon Memorial Lecturer for 1945. Dr. Hoskins, research associate in Physiology, Harvard Medical School, and director of the Memorial Foundation for Neuro-Endocrinc Research, Boston, as well as director of the Worcester State Hospital, Worcester, Mass., has for some 18 years devoted much of his time to research concerning endocrine disturbances in mental diseases.

"The Biology of Schizophrenia" will be the title of the Salmon Lectures which will be given at the Academy of Medicine, 2 East 103rd Strcet, on three successive Friday evenings next November.

## GRANT FOR HODGKINS DISEASE STUDIES

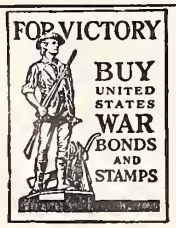
A $5000.00 grant has been given by Martha W. Hoster of Columbus, Ohio, to St. Vincent's Hospital, New York City for the Laboratory of Cellular Physiology and Pathology to conduct studies on Hodgkin's Disease with collaborators at New York University, Ohio State University, Columbus, Ohio, and Walter Reed General Hospital, Washington, D. C.

This fund will be administered by A. Rottino of St. Vincent's Hospital and C. G. Grand of New York University.

## WOMAN'S AUXILIARY MEETING

The Woman's Auxiliary of the State Medical Society will hold its annual meeting on May 23 at 2:00 P. M. at the New Haven Colony Historical Society, 114 Whitney Avenue, New Haven.



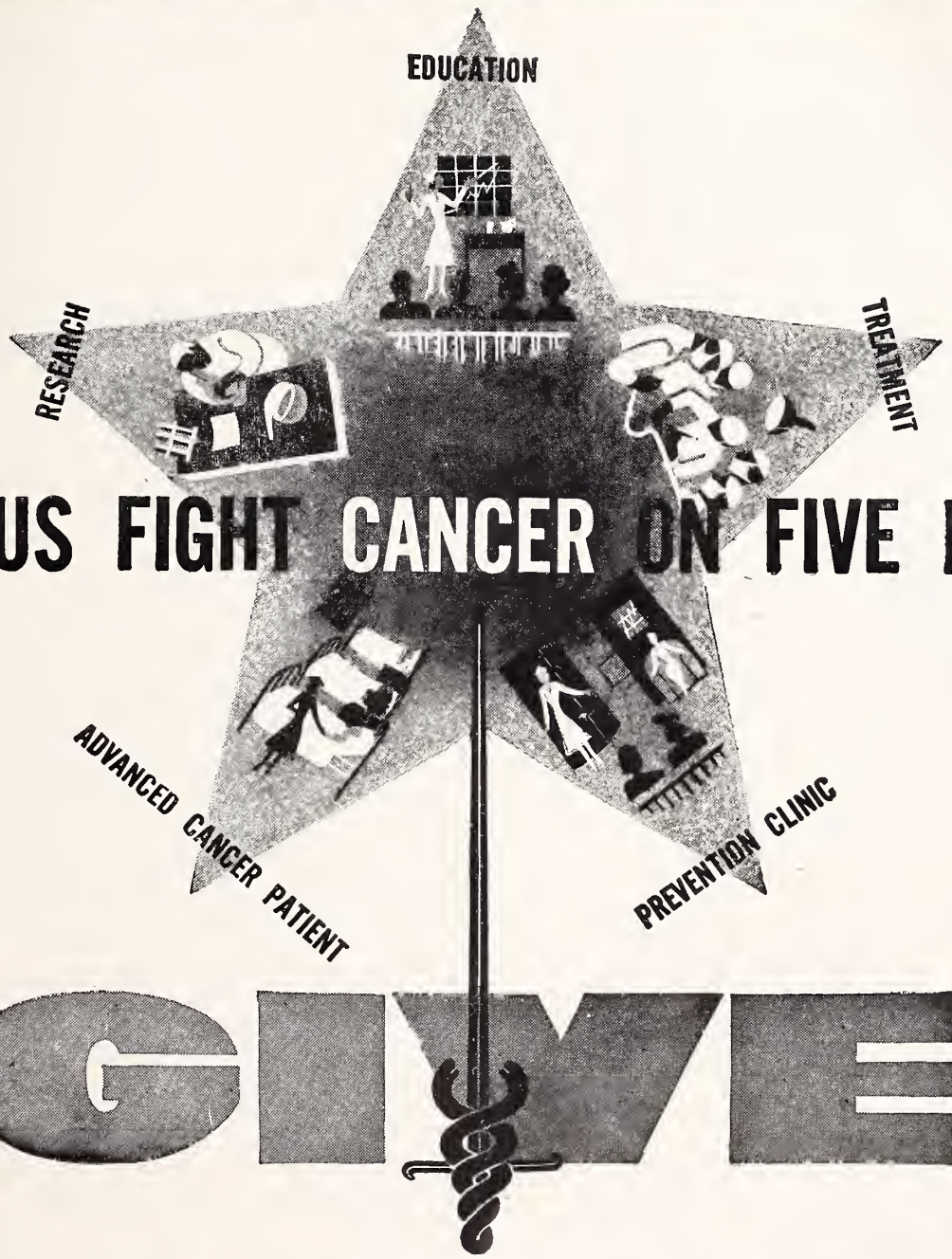




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(SEE PAGE 2)

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# GIVE

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**YOUR GIFT MAY SAVE YOU—OR THE LIFE OF SOMEONE DEAR**

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# OUR NEIGHBORS

## New York

Because an emergency exists in New York City in regard to office rentals, the Joint Legislative Committee on Rent Control has caused a bill to be introduced into the legislature to extend existing rent control legislation to cover offices. According to *New York Medicine*, this bill will include rent control protection for physicians' offices, whether they are in an office building or in an apartment house.

New York City through its Health Department has established the Tropical Disease Diagnostic Service with both laboratory and clinical facilities and with the advice and assistance of the specialists of the tropical disease staff of the DeLamar Institute of Public Health of Columbia University. To study the incidence of, and to be on the alert for the spread of these diseases, the Department has appointed in the Bureau of Preventable Diseases an epidemiologist, Howard Shookhoff.

In New York City J. P. Morgan and Company became the first subscriber to the so-called "doctors plan" called United Medical Service and endorsed by the Medical Society of the State of New York and the 17 county medical societies of the New York area. This plan covers individuals with incomes up to $1,800 and families within the $2,500 income bracket. Insurance covers complete payment of physician's and surgeon's fees for surgical operation, the treatment of fractures and dislocations and maternity care. Employees with higher incomes may be billed by their physicians for additional fees. J. P. Morgan and Company pays the full cost of the insurance for 681 employees and their families and supplements hospitalization insurance through the Blue Cross Plan of the Associated Hospital Service of New York.

Public Affairs Pamphlet, No. 101, 1945, is the story of Blue Cross by Louis H. Pink, president of the Associated Hospital Service of New York. He calls for a working partnership between federal, state and local government and all efficient and well directed voluntary efforts such as medical schools, dental clinics, research institutions, medical societies, Blue Cross Plans, voluntary hospitals, visiting nurse associations, and fraternal, social and educational bodies. Annual report of Associated Hospital Service of New York indicates assets of almost 14 million dollars in January 1945. In 1944, 144,130 bills were paid for members covering 1,500 different types of illness necessitating hospital care; 17,500 New York employers utilized Blue Cross, and 800 of these contributed all or part of the subscription charges. Present subscribers—1,804,127. In one month 30,000 members were added when restrictions on individual memberships were lifted.

## Rhode Island

Authorities state that the Rhode Island state operated cash sickness insurance system paid out $724,519 more than it took in during the six months from April 1 to September 30, 1944. Receipts by the fund have been declining and the amount of the average benefit check increasing.

# NEWS
## *from County Associations*

### Fairfield

Oliver L. Stringfield has been elected a member of the Bolivian Pediatric Society, South America. Dr. F. Torres Bracamonte, secretary general of the society is a former student of Dr. Stringfield's.

The 153rd Annual Meeting of The Fairfield County Medical Association was held on Tuesday, April 10, at The Stratfield Hotel in Bridgeport. The following officers were elected for the ensuing year: President, George B. Garlick, Bridgeport; Vice-President, John D. Booth, Danbury; Secretary, J. Grady Booe, Bridgeport; Treasurer, Clifton C. Taylor, Bridgeport; Councilor, Samuel F. Mullins, Danbury. The speaker of the evening was Major James E. Crane, MC—AUS, whose subject was "Operational Fatigue." Major Crane is a member of this Association and is the son of Ralph W. Crane of Stamford. He has been in service for the past four years and has served in nearly every active theatre of war. At present he is stationed at the Fort Logan Convalescent Hospital.

### Hartford

The 153rd annual meeting of the Hartford County Medical Association was held at the Hunt Memorial Building, Hartford, April 3. Reports of officers and committees were read. The following officers

and committeemen were elected: Edward A. Deming, Hartford, president; Aaron P. Pratt, Windsor, vice-president; D. C. Y. Moore, Manchester, councilor; Samuel Donner, Hartford, secretary-treasurer; Robert S. Buol, New Britain, censor (1945-1947); Stanley H. Osborn, Hartford, committee on public policy and legislation (1945-1946); Walls W. Bunnell, Farmington, Augustus R. Felty, Hartford, George A. F. Lundberg, Manchester, and Ralph A. Richardson, Bristol, delegates to State Medical Society. Three new members were elected: Jerome M. Hopper, Hartford; Roy L. Leak, West Hartford; Frank Zwick, New Britain. Following a dinner at The Hartford Club, George C. Adie, director of surgery at Grasslands Hospital, Valhalla, and at New Rochelle Hospital, New Rochelle, New York, presented an instructive and stimulating paper on "Some Present Day Problems of the Hospital and Staff." Dr. Adie's manuscript will appear in full in a subsequent issue of the JOURNAL.

## Middlesex

Norman Gissler of Middletown who has had several months of overseas duty with the United States Naval Medical Corps with the rank of Lieutenant-Commander has received his discharge from the service. He has resumed the practice of general surgery in Middletown.

The Woman's Auxiliary of the Middlesex County Medical Association held an organization meeting at the home of Dr. Jessie W. Fisher of Portland on February 14. The first regular meeting was held at Cromwell at the time of the meeting of the County Association and was exceptionally well attended. Officers of the new auxiliary are Mrs. Walter N. Nelson, president; Mrs. G. M. Craig, president-elect; Mrs. Louis O. LaBella, secretary; and Mrs. Charles Russman, treasurer.

The Middlesex County Medical Association held its 153rd annual meeting at the Edgewood Country Club in Cromwell on April 12. Augustus Rose of the Harvard Medical School discussed the use of Penicillin in the treatment of syphilis. Officers elected at the meeting were Chester Waterman, president; Charles Russman, vice-president; Frank Couch, clerk; Harold E. Speight, councilor. State delegates are Jessie W. Fisher, William E. Wrang, and Frank H. Couch.

## New Haven

George Blumer writes from Pasadena, California: "What am I doing? Consulting physician to the


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Huntington Memorial Hospital. In charge of the Heart Clinic, Pasadena Dispensary. Lecturing to nurses, Huntington Memorial Hospital and seeing cases with interns once a week. Preparing and presenting the clinical aspects of cases shown at the monthly Clinical Pathological Conference. This sounds like a lot and there is some work attached. I also see an occasional private patient. As usual they have loaded me up with financially unprofitable jobs but I get quite a kick out of them." As you see, Dr. Blumer has not changed and is still going strong.

The merger of the New Haven and Grace Hospitals is well on its way to a complete consummation and important meetings are being held at regular intervals so that this union can be realized in the very near future. The drive for funds and the architect's plans have already been submitted to the committee. This merger is of great interest to all in New Haven.

Gervase J. Connors of New Haven gave an interesting paper on the treatment of burns at the April meeting of the Waterbury Medical Society.

Walter Reilly has returned from two years duty in the Pacific for a 30 day leave at his home in Naugatuck.

Alexander S. Rogawski of Waterbury has been commissioned a First Lieutenant in the Army.

### New London

The annual meeting of the New London County Medical Association was held on Thursday, April 5, at the Seaside Sanatorium, Niantic. The following men were elected to office: John W. O'Brien, Waterford, president; Harold W. Higgins, Norwich, vice-president; Thomas Soltz, New London, secretary-treasurer; George H. Gildersleeve, Norwich, councilor; Hugh Lena, New London, and Albert C. Freeman, Norwich, trustees for three years. Dinner was served at 6:30 P. M. and at 8:00 P. M. the scientific session offered Morris Tager of Yale Medical School as the speaker with his subject, "Tropical Diseases." J. Raglan Miller, Hartford, and Drs. Florence Brown and Amy Breyer of the State Health Department were present as guests.

C. G. Thompson and C. E. Bilecki of Norwich were appointed part-time physicians at the Norwich State Hospital. Their work will consist in making the annual physical examinations of the patients.

The next meeting of the New London County Medical Association will be held on Thursday, May 3. This promises to be a most outstanding meeting. Dr. Richard C. Arnold, Marine Hospital, Staten Island, N. Y., will speak on "The Use of Penicillin in Gonorrhea and Syphilis." The meeting will be held at 8:30 P. M. in the surgical amphitheatre, Uncas-on-Thames. A cordial invitation is given all who will be in the vicinity of Norwich on that evening.

### Windham

William M. Shepard of Putnam has been appointed to the medical panel to replace J. A. Girouard who has resigned.

## News from Yale University School of Medicine

A lecture on The Organization of Russian Medicine in Wartime was delivered on April 11 by Prof. Vladimir Lebedenko. Prof. Lebedenko is representative in the United States of the Mission of Alliance of Red Cross and Red Crescent Societies of the U. S. S. R.

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*For the diabetic, Knowledge is Life*

OPTIMAL SUCCESS in the management of diabetes mellitus depends largely on the patient's knowledge of the disease. Physicians carefully educate their diabetic patients. Facts concerning blood and urine sugar, diet, exercise, Insulin, and Protamine Zinc Insulin are valuable steppingstones to successful treatment. Other things being equal, the well-trained patients live the longest.

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JOSEPH HENRY HOWARD, B.S., M.D., F.A.C.S.

Born in Bridgeport, Connecticut, August 30, 1892.

Georgetown University, B.S., 1916; M.D., 1918.

Internship, Bridgeport Hospital, Bridgeport.

1919-26, Assistant Surgeon, St. Vincent's Hospital, Bridgeport.

1926-27, European Clinics.

1927- Attending Obstetrician, St. Vincent's Hospital, Bridgeport

F.A.C.S.; Diplomate American Board of Obstetrics and Gynecology; New England Obstetrical and Gynecological Society.

Attending Gynecologist, Bridgeport City Dispensary. Consulting Obstetrician and Gynecologist, Englewood Isolation Hospital, Bridgeport, and Laurel Heights Sanatorium, Shelton

Past President, Bridgeport Medical Society.

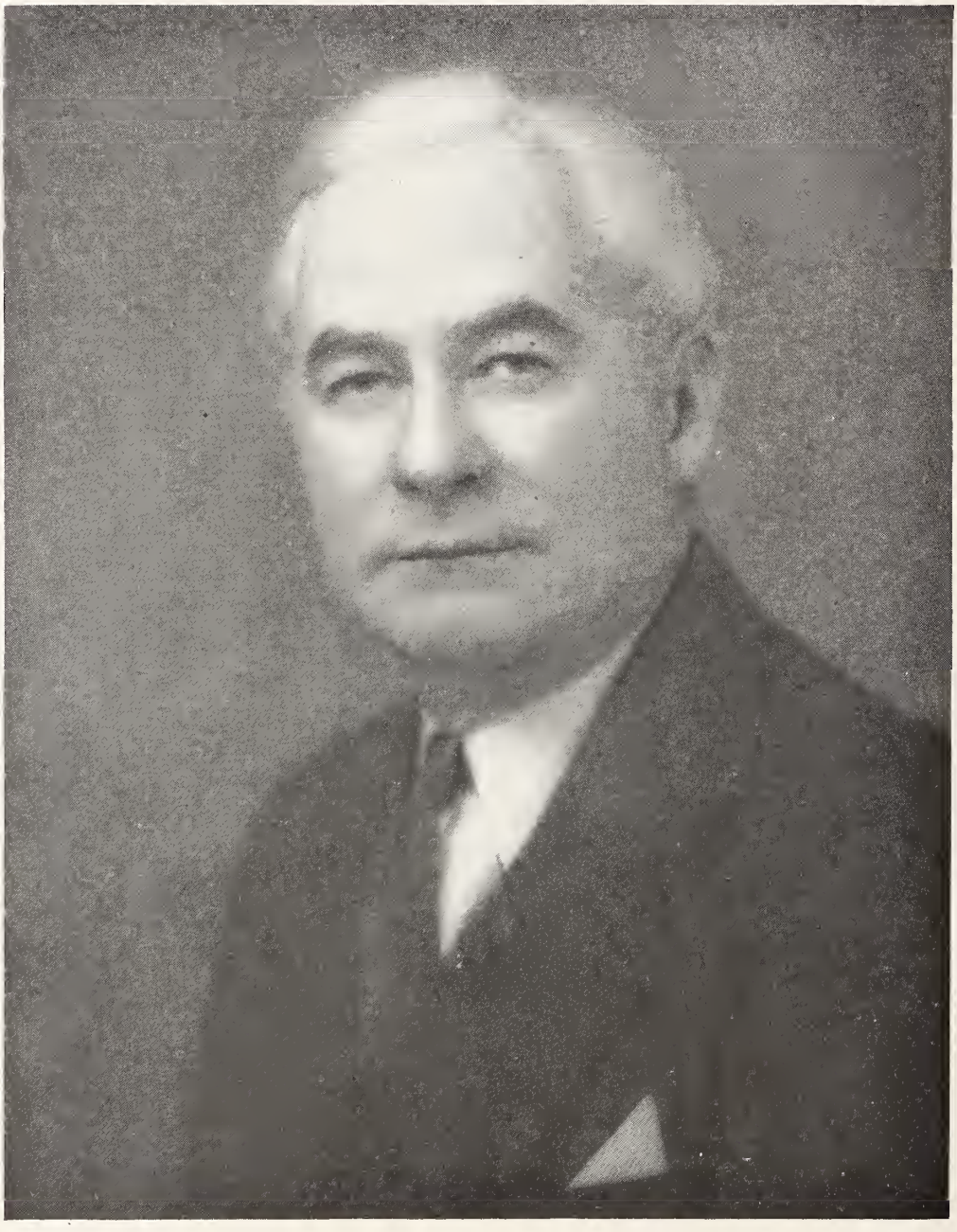
Past President, Bridgeport Rotary Club.

Member, University Club, Bridgeport, Brooklawn Country Club, Bridgeport, and Graduate Club, New Haven.

Chairman, Community Nutrition Service.

Chairman, Public Health Committee, Bridgeport Chamber of Commerce.

Chairman, Public Health Committee, Council of Social Agencies.



# Message from the President

## Connecticut State Medical Society

The first phase of the world's most devastating war is at an end. Complete victory is assured. With the return of our troups, problems are presented to the profession which must be met and solved promptly and efficiently.

Hundreds of our colleagues have made great sacrifices in entering the service of our country, and they must be assured of their rightful place in private practice immediately upon discharge. A helping hand by all who were fortunate enough to remain at home will do much to rebuild the practices of those who have given unselfishly that American boys could have the best medical care.

The discharge of a large number of troups places a tremendous burden on the Veterans Administration. Already the aid of the medical profession has been requested in many communities for special examinations. Due to maladjustment of scores of these young men, our patience at times will be tried. However, courteous treatment will be so important as an adjunct to direct them into proper channels leading to prompt and complete recovery.

In the past few years the medical profession has been the target of unjust criticism from several sources and has been faced with legislation both local and national aiming at radical changes in our system of medical practice. We cannot be indifferent to these accusations. The threat is real. It is only by the united effort of the profession as a whole that success can be assured.

Supplementing our activities is that of the public at large. By a well directed public relations program, it will be possible to combat unfair and distorted criticism directed at our private practice of medicine.

To these aims, I invite your whole-hearted cooperation.

Joseph H. Howard

The
CONNECTICUT STATE MEDICAL JOURNAL

VOL. IX JUNE, 1945 No. 6

# SOME PRESENT DAY PROBLEMS OF THE HOSPITAL AND STAFF

GEORGE C. ADIE, M.D., *New Rochelle, N. Y.*

EVERY hospital serving its community well is faced with constantly changing problems. If it does not keep up with the trend there soon comes the time when such a hospital is regarded as static. Consequently, the people living in the community and using the hospital might be deprived of certain advantages which are lacking as a result of failure of the institution to keep abreast of the times. In a sense, the hospital reflects the attitude of the medical staff and to an equal degree the awareness of the lay board and the ability of the management as exhibited by the director. In the last analysis it is a function of the medical staff to keep the board of Governors and the superintendent alive to the medical needs and help them plan for inevitable changes.

One of our most important considerations at this time, which may seriously affect the hospital as well as the staff, is the possibility of federal intervention. In fields other than our own, government has already imposed restrictions which have limited effectiveness in various ways. If a national plan for medical care should be instituted by the federal government, one of the steps in that plan, would undoubtedly result in many, if not all, local hospitals being taken over to become a part of the system. By such an act, the years spent in making the Hospital an efficient factor in its locality, and the individuality of the medical staff which stamps such a hospital, would largely be lost to the control of the local community. It is a reasonable supposition, that a hospital and the medical men, in a given area, might be doing such a good job that the government would eagerly engulf them in a compulsory medical care program, but it is likewise just as reasonable to suppose that this hospital and staff could be so effective that the government might feel that they should be left undisturbed to carry on in their own efficient way. It is logical to assume that, at first, hospitals which were not doing their utmost to provide good medical care, would be taken over and an attempt made to improve them under federal regulation. It behooves us to analyze our own situation and determine if we are doing a proper job, not only in present day effectiveness but in making our set up so strong for the future that it cannot be criticized. As a rule the average general hospital takes care of acutely ill medical and surgical patients. The scope of a general hospital should be far wider than that. It has the opportunity to offer a more inclusive coverage of medical problems which are now neglected or only slightly touched upon. To mention one field of endeavor, the care of elderly people in the hospital should be given special consideration. The practise of geriatrics has become a well established entity. Patients under this category who are not eligible for old folks homes often need prolonged hospitalization. They frequently occupy beds needed for acutely ill patients and in most instances are a burden to the nursing staff. These patients are scattered throughout the hospital with no particular thought given to their special needs. Patients with fractured hips, arthritis, cardiac disabilities and even those who are in good health sometimes want to stay in the hospital to receive extra care. Most general hospitals are not properly geared to efficiently care for this type of case. A certain part of the hospital, providing semi-private and private rooms should be set aside so that all patients of this class may be grouped for proper care peculiar to their needs, involving special nursing instruction and dietary differences.

*Presented before the Hartford County Medical Association, Hartford, April 3, 1945*

sanatoria and convalescent homes where these people may be sent are often too expensive for the average family to afford a long stay and do not offer proper medical supervision. The general hospital should provide a special place and special care at reasonable cost for elderly people. It could be a source of profitable revenue to the hospital and also a source of goodwill from the relatives of the aged.

Already the sanitoria for tuberculosis are overcrowded and a waiting list, too long, stares the superintendent in the face each day. The general hospital has an opportunity to relieve to some extent this situation. The diversification of treatment for pulmonary tuberculosis has made it possible to care for these patients outside a sanitorium, especially in the field of surgery. It is generally accepted that the tuberculosis hospital offers the most ideal conditions and this kind of a hospital is substantially provided with special equipment and trained personnel. It should be made clear that the general hospital should not be expected to replace, but to supplement the tuberculosis hospital. Only about one general hospital in twenty is prepared to give either partial or complete service in this field. There is evidence to support the belief that the incidence of tuberculosis is actually increasing. This is especially true in the warring nations. Undoubtedly thousands of our soldiers and sailors will be found to have the disease before and at the time of discharge. The mass surveys conducted by the armed forces, by industry, and the routine chest examinations for all in-patients and out-patients in every hospital as recommended by the National Society will produce many more cases of unsuspected tuberculosis. If all the existing sanitoria in this country, or in other countries, were taxed to capacity there would not be a sufficient number of beds to care for these cases. After the war new sanitoria will be built in various parts of the country. If possible these should be placed so that they are made a part of the general hospital, or instead of spending large sums of money to erect new tuberculosis hospitals, space in general hospitals already existing may be utilized or plans for tuberculosis beds in hospitals under course of construction may well be created. In the minds of some there may be certain objections to a tuberculosis division in a general hospital, however, if this department is isolated in such a way that traffic and infection are controlled and rigid protective measures are enforced, the hazard is reduced to a minimum. The tuberculosis division may well admit and study early cases preparing them for transfer to a sanitorium or tuberculosis hospital if it is determined that surgery is not necessary. Artificial pneumothorax, pneumonolysis and phrenic nerve interruption or other surgical procedures early and effectively instituted shorten the healing process and as a consequence, hospitalization is reduced. Where adequate protection is offered, far advanced, hopeless or moribund cases may be cared for in the general hospital, thus keeping these people in their last days out of the home but near their relatives. Old people with chronic tuberculous disease, more common than recognized, may be removed from their homes to the hospital and eliminate a constant and dangerous source of infection.

If a surgical program were instituted for the care of tuberculosis patients and a section of the hospital properly equipped to receive these cases, nearby sanitoria not offering surgical care would welcome such a service for transfer of surgical cases.

A tuberculosis hospital or a sanitorium should be a part of or closely associated with a general hospital so that disease processes requiring consultations in other departments could be easily and quickly carried out. Specialists in urology, ophthalmology, otorhinolaryngology, dermatology, and orthopedics should be readily available and assist in the care of these patients.

Many advantages would accrue to the staff from an active tuberculosis service. Interest in the disease would be enlivened by study and treatment of such cases. Staff conferences and presentations would enlarge the knowledge of the staff regarding various phases of the disease. Internes and nurses rotating through the department would have a first hand knowledge of tuberculosis problems. In too many general hospitals, the young doctors and nurses in training seldom see tuberculosis as they will encounter it in later practice. A certain number of these young people might be influenced to enter the specialty of tuberculosis as a result of their contact with a well conducted program.

The study of tuberculosis has to some extent been responsible for the increasing knowledge among medical men as well as surgeons in other conditions of the chest. This leads us to the desirability of establishing in every general hospital a clinic or department for chest diseases. This rightly should be under the guidance of the department of internal medicine, with the departments of surgery and other specialties participating in the diagnosis. When these cases

can be grouped for concentrated study, earlier and better diagnosis will be made and proper treatment can be instituted sooner. Many diseases of the chest which have hitherto been abandoned as hopeless now lend themselves to curative treatment. In view of the increasing prevalence of one disease alone—namely, bronchogenic carcinoma, every effort should be directed to the early discovery of this lesion. By surgery it can be eradicated and in certain cases a cure can be reasonably expected. Young people who have been social outcasts from bronchiectasis can be freed from their disease, of course, old people also, but to the young this is a particularly embarrassing condition. The earlier drainage of lung abscess should be encouraged so that the chronic stage which is too often reached may be obviated. Other suppurative lesions as well as benign tumors will be discovered and properly dealt with. A chest clinic will not only serve as a stimulus to diagnosis but will keep the staff abreast of the advances in every branch of this field.

One other function of the hospital and staff should be mentioned briefly and that is the running of a well equipped cancer clinic. Most hospitals are doing this today. It should be manned by men interested in cancer, preferably specialists in various fields and the clinic management of these cases should be integrated with the operating room and bedside. Every detail of the handling of each case should be recorded so that when histories are discussed and analyzed in the regular conferences helpful conclusions as to organic systems may be drawn. The time has now arrived for hospitals to establish cancer prevention clinics which is a step in advance of the already existing so called tumor clinics. This may be a function of the staff already engaged in the cancer control clinic or may be set up as a new clinic but my impression is that those working in this field in the control clinic would be admirably suited to conduct the search for precancerous symptoms and lesions, as well as investigating the suspicious case.

There is rapidly developing in every community a problem—affecting doctors, hospitals, and social agencies. It is a result of the present war. I refer to the many medical discharges from the armed forces due to neuropsychiatric disturbances. Unfortunately the Veterans Administration is not equipped to take care of these men. As a rule they are discharged home and become the care of the local community. Private psychiatric institutions are unable to cope with the situation even if the afflicted could afford to go to them. General hospitals certainly aren't equipped to admit such cases. Furthermore, when one realizes that in the whole country there are only about 3,000 military and civilian psychiatrists the problems become more complex because about 200,000 neuropsychiatric discharges need treatment each year. There will be a post war accumulation of about one million veterans with nervous disabilities for the limited number of trained psychiatrists to treat. In our community the Veterans Bureau has been asked regarding plans for these men and so far no satisfactory answer has been received. A great deal of thought has been given to this matter by local medical groups and by committees, but the most constructive plan that we have had presented comes from Dr. John G. Lynn, psychiatrist at the Psychiatric Institute of Grasslands Hospital. It is estimated that 80 per cent of the discharges in this category require psychiatric help and it is known that only 5 per cent have received such help. It is also estimated that 75 per cent of war neurotic discharges in New York City who need psychiatric help do not want it and will not accept it. Since many of these men are not using their homes and churches for social rallying points but do congregate at legion posts, Dr. Lynn has suggested that these be used as the focal points to arouse group feeling and stimulate a sympathetic attitude. He feels that the method capable of coping with this immense problem is the "help-each-other" technique of group psychotherapy,—a kind of Neurotic Veterans Anonymous. Dr. Lynn describes in considerable detail how he proposes to make this group therapy effective and believes that in addition to providing rehabilitation for the large majority of neurotic ex-servicemen it would have the additional value of being a referral agency to regular psychiatric clinics and hospitals for the more difficult and involved cases.

It is obvious that some of the remedial work cannot be successfully conducted in a legion post meeting room, more private surroundings will be necessary; it is in this part of the work that the hospital can cooperate. Classes for group therapy may need privacy, such space for these groups may be arranged in clinic rooms in out-patient departments or in assembly rooms. The atmosphere of the hospital would be conducive to closer attention on the part of the patient. Also certain men might require manual training as a means of rehabilitation and here

hospitals equipped with shops should offer this facility. Some of these patients may have minor physical ailments requiring hospitalization and medical care to further their complete recovery and in this need cooperation should be given. Since there is such a shortage of trained psychiatrists a few doctors in each community might well volunteer to take short courses in psychiatric treatment and thereby supplement the work of the more experienced specialist.

In New Rochelle we are planning an immediate addition to the hospital which is the first step in a long range plan to cover the next ten years at least. One objective of our future completed plan is a building which will be known as the Community Health Auditorium. We intend to hold meetings for the lay public for the purpose of presenting current medical matters of interest in such a way that correct information may be imparted by members of the professional staff. We hope to counteract the over publicized popular articles on medical subjects by lay writers, by having doctors with actual experience in the subject describe the results from a realistic standpoint, thereby creating a sane attitude in people regarding what might be expected from certain modalities. The value of new drugs of universal importance may be presented in an accurate manner, lectures on public health matters, on tuberculosis and cancer, new developments in medical science of broad interest may be dealt with in a simple and clear manner. Forums on medical matters, open to public discussion and questions, under the leadership of various members of the staff would be held. Such subjects as compulsory health insurance, medical indemnity insurance, federalized medical care, industrial medical liability, just to mention a few, could be aired for the benefit of professional as well as lay people. More intelligent decisions could be made on medical affairs which directly affect each individual as a result of such opportunities to meet on a common ground. We hope to create the feeling in the community that the hospital is the center to which any person may come seeking information and knowledge about any medical problem which may arise in his family. In this community building could be planned space for headquarters for the Red Cross, for the Public Health department, for the welfare department and for the various social agencies. If several of these organizations could be housed under one roof with the hospital as the center, it becomes apparent that closer cooperation would be obtained, not only between the agencies but between the hospital's various departments and the agencies. The hospital should certainly enter into and become a part of the peoples' every day lives, not only in actual illness but to be consulted as a source of advice where indecision exists, and to show that the professional personnel inside the four walls is capable of a sympathetic attitude toward individual problems. Just as the church is the center of the spiritual life, so should the hospital become the center of the medical life of its community and perhaps with an equally great opportunity for service. In order to stimulate interest in the hospital by people living within its range of activity we started last year a plan to bring them into the institution as visitors. A group of 25 to 30 men and women is invited from 3 to 5 o'clock every second Sunday afternoon. The members of the Board of Governors take turns in inviting the guests and with each governor is a physician and the superintendent, acting as hosts. A tour is conducted by the above mentioned officials, visiting the record room, the x-ray department, the therapeutic pool, the outpatient clinic, a typical private room, if one is empty, a typical operating room and other interesting places. A brief description, by the host guide is given as the tour progresses. Following this part of the program the guests are then served a light collation. It is surprising the interest shown by every visitor. Not only is goodwill built up for the hospital but in the course of time hundreds of people come to regard the institution with confidence and seem to develop a personal friendly feeling for its facilities when the need arises.

The points which I am about to mention, regarding the doctor returning home to take up his practise after being in service, have been given a great deal of consideration in our county, as I am sure they have in yours, but I do think they are important enough to go over briefly. Namely, to assure every physician that his staff appointment is ready and waiting for him to resume activity; in other words this important hospital affiliation has been protected for him during his absence. For the most part our depleted staffs have taken on the work of the men in service and new appointments have not been made since they enlisted. We should assist him in every way to re-enter active practise by helping to secure office space, by lending or giving hard-to-get equipment, by offering financial aid through the County society wherever necessary and to make him feel he is welcome among his colleagues. Medical disability clinics, short courses of instruction in cer-

tain specialties and refresher courses in the more common diseases with which he has been out of contact should be arranged. We who have been at home may also benefit by having the returning servicemen give us courses in the various fields of military medicine he has been engaged in, not commonly encountered in civilian practise. Certain physicians at the time of discharge may have some physical disability as the result of his service. He may wish to consult doctors in his home locality as to the extent of his disability and the prognosis. We have set up a group to act in this capacity with a view to advising any applicant, perhaps more accurately than he can decide himself, just how much he can insist on a fair and adequate disability rating from the discharge board. These are a few of the things which can be done to make the man who has made a sacrifice feel that, in a measure, he has been repaid.

One other subject which deserves consideration has to do with the education of the present medical student. This was so ably brought to our attention by Dr. Evarts A. Graham in an article appearing in the *Saturday Evening Post* of January 27, 1945. If you haven't read it I recommend that you do so. It seems that interns finishing the accelerated courses display, for the most part a reasonably sound academic background. In some instances, however, there seems to be an inadequate amount of basic instruction. This may be due to the lack of time, in the accelerated plan to cover the work, and no doubt the depleted teaching staff in many of our first class medical schools does not provide the manpower to give adequate classroom and bedside instruction. While the accelerated program is not ideal, it certainly is less effective when the teaching personnel, so necessary to make it as ideal as possible, under the circumstances, is drafted from our medical institutions. According to Dr. Graham our medical faculties have been reduced 40 per cent, which throws a tremendous burden upon those left in the schools to try to include in the teaching program everything taught in the pre war courses. When the Army and Navy decided to streamline the curriculum, more consideration should have been given to the depletion of the faculties which provide such high grade instruction.

Perhaps the shortened course, and the drafting of medical teachers became necessary, but when the wisdom of curtailing the most important part of a young doctor's training is questioned, namely the internship, then those who decided such a step are open to criticism. I refer now to the nine months' internship or the 9-9-9 plan. No hospital can rotate an intern through the necessary specialties in nine months and send him out to the armed forces as fully prepared as he should be. In the hospital the young doctor learns to apply what he has learned in medical school, it is the practical part of his training, where he learns to give the best care to bodily ills. To become a good doctor, qualified to enter the practice of medicine, one should spend at least two years in a hospital, and before qualifying as a specialist, at least five years in all are required. To expect such competency in a young doctor under the 9-9-9 plan is asking too much. A junior residency for the second nine months and a senior residency for the third nine months is a poor substitute for five years of training. If the Army and Navy feel that by reducing the important training period to such a short time, good doctors will be provided sooner, they will, before long, find that the quality is not up to the standard secured by the Armed Forces before the 9-9-9 plan was adopted. Obviously, this means a sacrifice in the quality of medical care rendered to the soldiers and sailors. At no time in our medical education plan was our young doctor group so well prepared as at the beginning of this present war and it is safe to infer that much of importance is going to be lacking in the near future in our young doctors if the 9-9-9 plan continues for any length of time.

When the war is over many soldiers and sailors are going to complete their education at Government expense. A large number will study medicine. It should be the duty of the Government to provide these students with the best possible training, not only because the war prevented them from getting it when they were ready and it was available, but because it is necessary for the medical needs of the armed forces and the civilian population of the future to supply properly equipped doctors. When the time comes may we hope that the Army and Navy will abandon the acceleration in study and practise and return to a plan that gave us the best our medical schools and teaching hospitals had no offer. There is one drawback to this hope—and that is—if these young veterans are to be schooled at public expense the shortest method at the least expenditure of funds may be the prevailing rule. However, we should be optimistic and still hope that some deliberate judgment will be exercised in the final decision.

In conclusion, I would like to encourage the idea

that the general hospital can be a greater factor than it is by offering a broader field of service to the residents within its area, which implies, of course, that the doctors of the staff and the hospital administration must have the desire and the vision to make such a plan possible.

My remarks have been purely for the purpose of bringing to your attention some of the problems we are thinking about in my bailiwick, problems which must be common to your group and mine and I am sure you have given as much thought, if not more, than we, to these matters. If we can be of mutual assistance, in any way, in arriving at a solution, I, for one, will be only too glad to have the benefit of your thinking and would welcome your cooperation.

# CANCER ORGANIZATION AND PROPAGANDA

## Suggestions for Its Improvement

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IT IS WITH considerable hesitation that I propose to discuss the present American Cancer Society (formerly the American Society for the Control of Cancer) and its subsidiary, The Field Army (formerly the Women's Field Army) to criticize the lay propaganda being released by these organizations, and to suggest that there is a need not only for change in the type of propaganda but also in the structure of the organization itself.

As Chairman of the Connecticut Tumor Committee for 10 years and as Chairman of the Connecticut Division of the American Society for the Control of Cancer for three years a unique opportunity was given to me not only to help form a state cancer organization and to study the so-called national cancer organization but also to form definite conclusions in regard to these subjects. It is my hope that these conclusions may be of help to other states attempting to form adequate state cancer organizations and may arouse this Society and other state and national cancer associations to take an interest in the formation of a National Cancer Association with members appointed or elected by organized medicine. I feel that if we as physicians do not take immediate steps to control the national organization that such control will be irretrievably lost to our profession.

In order to set up an efficient, practical cancer organization it is necessary to know not only its objectives but also the obstacles that prevent the complete fulfillment of these objectives. The objectives are:

(1) The prevention of cancer.
(2) The early diagnosis of cancer.
(3) The cure of cancer.
(4) The reduction of cancer morbidity.
(5) The stimulation of cancer investigation.

Even a cursory scrutiny of the above reveals that any program instituted to accomplish these objectives must be under the direction and supervision of the medical profession—for they alone understand the problems involved, and, inasmuch as the medical profession as a whole will be criticized or praised for its success or failure, it follows that organized medicine elect or appoint members on the committees that form the whole cancer organization.

To comprehend the limited results that can be obtained by even the best cancer organization and propaganda, it is necessary to know that there are definite obstacles, due to our present limited knowledge of cancer, that will prevent the complete fulfillment of the above objectives.

(1) Cancer is not a simple disease caused by one agent but by many unknown agents, and until these agents are known and controllable it will be absolutely impossible to prevent cancer formation except in the external cancers which comprise 25-30 per cent of total that can be seen and felt by the examin-

*Read in part before the New England Cancer Society, Portland, Maine, October 13, 1944*

ing physician when the growths are still in the early stage.

(2) Only early cancers, that is cancers that are still localized at the site of origin, can be cured by x-ray, radium or surgery, our only present means of fighting this disease.

(3) About 65 per cent of all cancers are internal cancers and these rarely give any signs or symptoms by which they can be diagnosed until they have developed into the advanced stage when they are usually no longer confined to the site of their origin, but have spread to distant organs and tissues.

(4) That there is no means at present of salvaging the greater proportion of these advanced cancers. The few that are being saved are saved only by the increased skill of the radiologist and the surgeon.

These obstacles set a definite limit, therefore, to the percentage of cancer cases that could be cured if everybody followed the instructions and advice of physicians.

The above facts obviously could not be known by the group of physicians who in 1913 banded themselves into a group which they called the American Society for the Control of Cancer. The Society elected officers and stipulated that the Society should be a self perpetuating one—new members being voted in by majority vote of their own members.

This Society met from time to time and considered the cancer problem as a whole and the ways and means by which its ravages might be curbed. It early (1914) advocated that Public Health Departments should take active interest in cancer control.

By 1928 it was sending out medical field representatives to make contact with state and county medical societies and to encourage them to establish cancer committees, and today they have succeeded in establishing state divisions of the American Society for the Control of Cancer in all but three states, namely, Wyoming, New Mexico and Massachusetts. The latter state has an efficient organization of its own and feels that a hook-up with the American Society would be detrimental rather than beneficial to their state organization.

One of the best contributions that the American Society gave towards the control of cancer was the recognition of the fact that the individual cancer case can best be handled by a group which would include surgery, radiology, pathology and other specialties. No one physician can hope to have in his mind all the necessary knowledge pertaining to a cancer case that a group, such as this, can bring to the consideration of the case.

The American Society advocated the formation of Tumor Conferences and Clinics in hospitals throughout the United States so that each cancer cases would have the benefit of group study and care. This recommendation was recognized as a good one by the American College of Surgeons and in 1931 the College requested and received from the American Society for the Control of Cancer the privilege of establishing and supervising the activities of these tumor conferences and clinics.

All credit should be given to the original members for having the initiative and the necessary vision to set up the American Society for the Control of Cancer. They did a grand job as far as they went, but, as always happens in these self perpetuating groups, old age demanded its toll and in spite of the influx of new members, some of the fire and enthusiasm left the group. The older men became aware of the limited results obtained through propaganda for the control over cancer. One of the charter members, Dr. James Ewing (page 3, Chapt. 1, "Treatment of Cancer" by Drs. Pack and Livingston) persistently pointed out that "about 75 per cent of the cancer cases are no longer early when they get into the hands of competent physicians and surgeons for treatment and this is a definite obstacle since the figures have changed but little in spite of the organization that has been set up to correst this condition." He further pointed out that "65 per cent of the total incidence of cancer falls in the groups of stomach, liver, esophagus, lymph nodes, lungs, pancreas, gallbladder and other internal organs, and that little or nothing could be expected from curative medicine under these conditions."

But, just at the time when the affairs of the American Society for the Control of Cancer were at the lowest ebb, new life was pumped into the Society by the appointment of Dr. Clarence C. Little to the position of Managing Director. Shortly after this appointment Mrs. Marjorie B. Illig became an employee of the Society and she suggested that she could organize a Women's Field Army which could be the agent, not only for the raising of the needed funds, but also could be used for the dispersal of cancer propaganda. This idea was taken up by the American Society for the Control of Cancer and the Women's Field Army came to life eight years ago. Since then it has become the dominant force in the cancer field.

It was determined from the first that the Women's Field Army should be militant and aggressive, and that the propaganda should be optimistic and imaginative, in order to catch and to hold the support of those who volunteered to aid the work. The symbol of this Army was to be a drawn sword. It's slogan, "Fight Cancer With Knowledge."

There is no question but the structure of the Women's Field Army is adequate for its purposes. At the head of the organization is the National Commander, and the Regional Commanders. The United States is divided into groups of states, and District Commanders and Vice Commanders rule these districts, and each state has a State Commander and Vice Commanders, and the states are divided into districts with commanders and vice commanders over these state districts. Then the towns and cities each have their commanders and vice commanders and captains and lieutenants over sections of the city, and under these are the workers,—(one worker for every ten to fifteen families is suggested). In each of these sections and towns and cities there must also be appointed by the medical profession a physician who will agree to head this group of women workers, supervise their activities and try to prevent them from doing any harm to the cancer program and to the reputation of the medical profession. To keep this tremendous army of women interested and willing to continue to work, it is necessary to feed them more and better optimistic cancer literature which they distribute while they solicit dollar memberships.

Most of the literature distributed is supposed to be, but rarely is, edited by a committee of physicians. Some of it is good, but most of it is based upon a misconception of the cancer problem and represents untruths or half truths.

A typical example of this type of propaganda is a counter poster that shows a happy family walking confidently into the future knowing that they will all be spared from cancer simply because they have learned the danger signals, which will indicate to them the presence of early cancer, and they are happy in the knowledge that they are secure from cancer. Even the Women's Field Army should know by this time that only external cancers, composing about 35 per cent of the total cancer incidence, can be detected early. There would be some point in fooling the public if lives were to be saved by false propaganda, but certainly lives will be lost if the people are given the idea that they can safely wait for cancer signs and symptoms to appear before seeking advice. The time to find most precancerous lesions and early cancers is before any signs and symptoms appear.

The Women's Field Army claims that there are about 150,000 deaths each year in the United States from cancer, and that competent authorities state that 100,000 lives can be saved. A direct question asking for the names of these authorities failed to uncover any information.

A request to the Women's Field Army asking for the information that will protect a family from cancer and will be the means by which 100,000 lives are to be saved every year results in the acquisition of a single sheet of cancer propaganda entitled "Keys to Cancer Control," which reads as follows:

Key 1. Go to a competent physician at least once a year for a thorough physical examination.

Key 2. Watch for these Danger Signals—usually painless—that may indicate the presence of cancer.

1. Any persistent lump or thickening, especially in the breast.

2. Any irregular bleeding or discharge from any of the body openings.

3. Any sore that does not heal, particularly about the tongue, mouth or lips.

4. Persistent indigestion.

5. Sudden changes in the form or growth of a mole or wart.

6. Any changes in bowel habit.

This, then, is the information that will save 100,000 lives a year and it is for the distribution of this information and of course, to a lesser degree, for the collection of money, that the Women's Field Army has been organized.

The title "Keys to Cancer Control" itself is not a strictly honest statement because control means "to exercise governing influence over" and there is nothing in these keys that is going to have a governing influence over cancer.

Key 1 advises the public to "go to a competent physician once a year for a thorough physical examination." This is probably the best advice that can be given to preserve health and bodily vigor. Such an examination should pick up about 25-35 per cent of cancers in the early stages and these, for the most part, will be external cancers. A yearly physical examination should prove beneficial but it is not a cure-all and why not say so. Too optimistic promises as to results obtainable by yearly physical examinations will unavoidably end in loss of con-

fidence by the public for the medical profession.

Neither does key 2 provide real cancer control.

(1) If a patient finds a lump in her breast she should go at once to her physician, but the chances are that when a woman can feel a lump it is no longer early. However, it is good advice and if all doubtful lumps were routinely removed there would be a definite drop in the incidence of cancer mortality from breast cancer.

(2) If irregular bleeding or discharge from any of the body openings occurs the cause should be investigated. But why give the erroneous impression that if the patient reports at once to her physician, the physician will find an early cancer and will be able to cure it. The vast majority of early cancers do not bleed and do not give off discharges. Women in particular should not wait for such symptoms to appear because about 25 per cent of cancer in women occurs in the cervix, and a yearly examination before any signs or symptoms appear would result in the detection and eradication of many instances of cervical cancer. The advice "watch for abnormal bleeding and discharges" means to most women that they can safely wait until such signs do appear and then if they report immediately to their physician the doctor will be able to control the cancer.

(3) The advice that all people who have slowly healing sores around the mouth, tongue, lips and skin should report within a month for treatment is good advice. If followed the cancer mortality from these areas would be entirely eliminated.

(4) However, the suggestion that stomach cancer can be controlled by seeing a physician as soon as one develops persistent indigestion is just a plain falsehood. Stomach cancer has no early symptoms and when these symptoms do appear the cancer is already advanced and treatment gives but negligible curable results.

(5) Good advice is contained in number 5, which advises the removal of all growths and moles and warts that show sudden changes in growth.

(6) In regard to change in bowel habit, i.e. alternating constipation and diarrhea, when these symptoms appear the chances are the growth is no longer early.

I have no doubt but Dr. Little and his corps of lay writers are doing their job to the best of their knowledge and ability. The fault lies not with them but with the members of the American Cancer Society who are evidently too busy to guide and direct the activities of these propagandists.

There is a need for a very limited and medically censored lay cancer education, but it must not be optimistic or imaginative beyond the truth. It is easy for lay propagandists to promise early diagnosis and cancer cure, but it is impossible for the medical profession in 60-70 per cent of the cases to back up these rosy promises. There is no necessity for setting up a huge Women's Army to distribute this limited propaganda. The organized medical profession working through the state departments of health and the health departments of the cities and towns could easily disburse all the necessary lay cancer propaganda. This is such an obvious fact that it has caused the writer to wonder why such an intricate, overwhelming organization such as the Women's Field Army (The Field Army) should have been concocted to do such a small job. The answer apparently lies in the potentialities inherent in this vast organization to raise funds. Dr. Little has persuaded the Cancer Society that a concerted drive should be made for more funds for scientific research if the cancer program is to be brought to a successful conclusion. It is the old belief that everything can be solved if enough money is available. Unfortunately, money doesn't breed ideas. Billions of dollars and years of research will be needed to investigate all the fields of science that must be investigated if the causes of cancer are to be discovered, for, as R. E. Kendall in "Cancer," published by the Connecticut State Department of Health, P. 19, has stated, "the mass of factual and experimental data accumulated during this century leads to the conclusion that the pathogeneses of neoplastic disease is not to be found in a single etiological factor, but involves a complexity in which hereditary constitutional factors, intrinsical physiological or metabolic and extrinsic chemical physical or biological agents play a part?" In other words, the solution of the causes of cancer are locked in the secret of cell life and growth and death. Already the Federal Government has provided for the establishment of the National Cancer Institute at Bethesda where adequate facilities are available for cancer research and where the authorities wait with open arms and adequate financial backing for anyone with an idea that has the remotest chance of solving the cancer problem.

It has been my observation here in Connecticut that what is needed more than anything else is an enlightened medical profession versed in the detection of precancerous and early cancerous lesions and provided with the modern equipment necessary for

ts proper treatment and trained in its use and in the skill that is required to perform cancer surgery.

Time does not permit a detailed description of the Connecticut State Cancer Organization, but anyone interested in this subject may find a detailed description of the Connecticut organization in *Cancer*, edited by the Connecticut State Department of Health, Chapter II, page 12. Suffice it to say that—

1. The Connecticut Cancer Organization has directed its activities toward the education of the doctors and only to a lesser extent towards the education of the laity.

2. It has found that a Cancer Division of the State Department of Health is an indispensable part of any state cancer organization. This cancer division not only collects statistical data on 95 per cent of all cancer cases that occur in Connecticut, but also has been helpful in dispensing the cancer literature which is needed for the limited instruction of the public, and has also helped in the education of the doctors through bulletins and pamphlets. The publicity is all supervised and edited by the reading committee, made up of members of the Tumor Committee.

3. The State of Connecticut allots $50,000 a year to pay the expenses of this organization. This includes salaries for the personnel in the Cancer Division and for secretarial help in the various tumor clinics, and diagnostic x-rays and biopsy examinations for the indigent.

4. The Connecticut Tumor Committee has decided against the formation of State Cancer Hospitals believing that the General Hospitals having tumor clinics could easily be equipped with the necessary x-ray and radium requirements and that the medical and surgical personnel would soon develop the necessary knowledge and skill.

The State of Massachusetts believes that their Cancer Hospitals justify their existence in spite of their high cost to the tax payers of the State, not only for the excellent cancer work that is performed at these institutions but also for the excellent instruction that is provided for interns. These interns carry their surgical cancer skills far and wide and help to raise the general level of cancer treatment in any community to which they migrate. All state cancer organizations should supply some hospital or hospitals where not only interns can gain training in cancer but where practicing surgeons may continue to increase their surgical knowledge of this disease. One factor that prevents small community hospitals from showing cancer cures comparable to the cures obtained at the larger cancer centers is the fact that the surgeons in the larger centers gain more cancer experience because of the greater number of cancer cases that come under their care. In the smaller communities there is a relatively small number of cancer cases to be distributed amongst a relatively large number of surgeons. The result is, that rarely does one of these small community surgeons develop the cancer skill comparable to that of a surgeon in a large cancer hospital. This obstacle might be overcome in various ways. For instance, The American College of Surgeons already recommends that cancer cases should have the benefit of group consideration for diagnosis and recommended treatment. It would be a logical step for the College to insist that major cancer cases be operated upon by teams of surgeons and that the chief of such a team should have at least a minimum specified cancer training. A private surgeon desiring to perform a major cancer operation could be required to have as his assistant one or more members of the cancer team.

5. One particular defect with the Connecticut Cancer Organization is that differences of opinion may arise between the State Tumor Committee and the Cancer Division of the State Department of Health. But this fault could be easily remedied by having a State Commission appointed by the Governor, and by granting this Commission authority to settle all such disputes.

6. The Connecticut Cancer Organization is far from perfect, but it has shown that there is no need for the outlay of large amounts of money if the organization is to perform its main function, that is the education of physicians. To make the organization really efficient there should be a full time executive officer who would carry out the directions of the Tumor Committee. The logical man for such a position would be the chief of the Cancer Division of the State Department of Health.

In conclusion it is suggested:

1. That if the main function of a state cancer organization is the proper education and training of the doctors, then by the same token the American Cancer Society should direct its main efforts toward standardizing the cancer organizations in every state in the union.

2. If, as I have tried to point out, there is but a small amount of cancer education that is needed

for the education of the laity, then there is no need for a vast Field Army to accomplish what now can be done by the existing agencies.

3. If the National Cancer Institute at Bethesda is willing to back with funds all worthy investigations toward solving the cancer problem then there is no need for the American Cancer Society to take on this added burden of raising funds for cancer investigation and again there is no need for a Field Army.

4. There is a need for a National Cancer Society with members elected by organized medicine and responsible to the medical profession. The present American Cancer Society could become such an organization by changing its rule of membership but if it does not wish to become a National Cancer Society responsible to organized medicine, then organized medicine should take the necessary steps to set up an organization of its own.

# THE IMPACT OF THE CANCER PROGRAM ON THE MEDICAL PROFESSION

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In the study and control of cancer the first procedure is the tabulation of all the related facts—the incidence, the site of attack, the virility and the expectancy. Records of all known cases are kept and one group of medical men must be employed constantly to analyze these records. Such an agency is established in the Department of Cancer Research of the State Department of Health. Since cancer is now reportable, hospitals send their records to Hartford and much that we say about the disease and the clinics and the program is based on the data compiled by Dr. Griswold and Miss MacDonald. For ten years the medical profession has received information at frequent intervals in the Department Bulletin on the course and outcome of the work done. This coupled with the conferences and papers presented at Clinical Congress and county meetings have so far had little effect in arousing the profession. Nevertheless this is the primary attack on the cancer problem and a measure of results.

Secondly, we continue to study the morphology of the disease. It is now many years since Percival Pott described chimney sweep cancer. It is thirty years since the Japanese investigator discovered he could cause cancer by rubbing tar on the rabbit's ear. Kenneway is still writing of the estrogen stimulus. Such tests have focused attention on an "irritant" cause of atypical growth but no common denominator has been discovered.

The appearance of the disease in the breast and in the neck of the womb in multiparae gave impetus to "repeated trauma" as a possible cause. Hot foods, seasoned foods and other substances ingested have been blamed for cancer of the stomach but none of these factors could be anything but remotely connected. Perhaps more than one entity has been grouped under the term "cancer." It might be a good time to renew interest in the subject by unlearning all preconceived notions and approaching the problem with a more open mind.

There are hundreds of islands of cells in strategic locations that live, maintain normal growth, even attain some size, but which are restrained and fulfill a normal life cycle, so that they may be construed as dependent, benign foci. All of a sudden some change takes place in the patient's metabolism, of a constitutional character, and these islands become centers of atypical growth of many grades of virulence often activating more than one area in the same patient. This internal activator is not as yet identified.

The only remedial measures recognized are three: Surgical extirpation, x-ray or radium irradiation. For some unknown reason the incidence of cancer is becoming greater year by year. This may be a real increase or an apparent one due to the fact that a larger proportion of the population is now living into the critical age zone. The increase of incidence, the psychology of the public, the defeatist attitude on the part of the laity and physician bring cases to expert attention when the advance has been so great that remedial measures are ineffective. Nevertheless, gradually the proportion of total salvage of afflicted

*Read at the Semi-annual Meeting of the Windham County Medical Society in Willimantic, April 19, 1945*

cases has been increased.

Physicians must learn to recognize the disease, by their senses if possible and certainly by study of every manifestation under the microscope, hence there must be more well trained pathologists. Certain men must be trained in physics so that the forces in that field may be used to the best advantage. Other men may be skilled in the means of removal by surgery. All of these are only of use when the case is readily discovered by the regular attending physician.

All agencies complain that the salvage is low because of the time lag between symptom and doctor, doctor and consultant, consultant and diagnosis; between diagnosis and hospital, admission and treatment. These statements are repeated as a reminder that the diagnosis and care of cancer patients has long passed the skill of any one man but requires a large, well trained group. It is realized that some types of the disease are so virulent that by the time the first symptom appears, extension has already reduced the expectancy, and recovery is doubtful. Fortunately, this applies to a small group. The total savings still maintain a hopeful curve.

The most common clinical criticism is that the cases are too far advanced when first seen. Taking a lesson from the National Tuberculosis Association, the Mental Hygiene Society, the National Association for Poliomyelitis and similar groups, some years ago the American Cancer Society was organized, and this year with the help of able business interests has held a nationwide campaign of education and fund raising. The first approach by the Cancer Society is a concerted program to alert the laity, make them cancer-conscious, urge them to consult at regular intervals, possibly provide places where cases may be examined for early detection. This cursory resume should make evident the fact that the key in cancer control is the physician.

The question is—are physicians ready and equipped and able to meet this call? There have been many extra demands on them during the past three years, they are not yet able to breathe deeply or sleep soundly. How gladly the physicians will welcome a hundred extra demands mostly from excited laymen with cancer-phobia? Consider the hospital administrator's feelings when he hears that $700 worth of x-rays may be required before one cancer case is discovered. Think for a moment of other economic aspects—these patients are ill for a long time, may require extensive procedures, are economically unproductive for much of this period, most of them have family obligations as well, which temporarily they cannot meet. What constitutes indigence for the usual industrial accident or heart disease is nothing compared to the burden of a cancer treatment.

Thought provoking, too, is the fact that 4,800 cases will be discovered this year in this State if the current rate continues. That means that each practitioner may see four cases. If, in one emergency, the practitioner must be constantly advised to be alert for the early discovery, every one of a thousand cases must be examined more and more carefully or some one of these four will be overlooked. If delay occurs in each case until the diagnosis is obvious, it is too late for cure; the pathetic, tedious, wearing attempts at palliation must be continued and there is little wonder that such experience depress the practitioner and make him feel that "nothing is being done for this condition." In the meantime, isn't it a question whether the doctor can find time or equipment for these thorough examinations or the patient afford the laboratory, x-ray, pathology and time costs? Some would remind the physician that economic problems are the responsibility of the State and that the training of the physician is the province of the Medical School and these are "none of his business." However, no one has more authority or right than the medical profession and the program is going to provide for more alertness and skill on their part. Plans to strengthen the tumor clinic are needed; a way must be found to improve technique of examinations and these must be provided for by the profession.

Medical officers will soon be coming home from the war. Most of them have expressed a desire for refresher courses and many are eager to assume posts that require special training. These opportunities must be provided. Many of the present staffs in the tumor clinics would be grateful for a tour of duty in some of the centers where advanced methods are now in use. Such men must have a grant to make this available. More men trained in pathology are needed and men trained to use x-ray and radium are far too few.

Promises have been made that funds from the cancer drive will provide better service for patients. This includes case finding, transporting the patient to the clinic, care of the family while the wage earner or the housekeeper are under treatment and underwriting special charges that cannot easily be

met by an otherwise economically sufficient family. Provision must be made for special appliances (masks, corsets, artificial limbs, etc.) and finally custodial care of the chronically ill. Some day these may be provided by the town poor fund or the department of welfare, but meantime they should be provided and the physician will be called on to see that this is done. Too much of this program should not be delegated to those outside the medical field.

The improvement of the clinic is of vital importance. Any suggestion in this area is fraught with danger unless it is carefully managed by a medical group. The present point system of credit for clinic service is inadequate in the opinion of many. It is difficult and dangerous to make generalizations, for what might be an improvement for a small rural clinic does not necessarily meet with approval in a big urban centre and vice versa. Whether these clinics shall be opened to pay or part pay patients would best be determined by the local medical group. If fees are to be collected, then the attending physicians should certainly be paid. Many think better control of the clinics would follow a practice of paying small sums to all the men rendering service therein. Probably under the present plan of procedure, the most vital key in the tumor clinic is the lay secretary. Dr. James R. Miller has aptly described her as a "Dorothy Dix type of trained social service worker with the insight of a clairvoyant and the tact and patience of a saint." One of the most far-reaching benefits to be derived from the recent drive might be the subsidizing of such a paragon for each of the existing tumor clinics. Such a person could explain the procedure to every inquirer, refer pay patients to their doctor, make clinic appointments, keep the medical attendants present when patients are to be seen, and above all see that the records are kept.

There are research funds available, the trouble is that very little has been applied to the use of such funds for clinical research. There is little being done in research on treatment. The American Cancer Society is devoting 10¢ out of every dollar of its share to correlation of research under various scientific committees carefully selected in each of several fields of approach. In Connecticut all of our funds are to be controlled by a committee of lay businessmen and a small scientific committee will pass on projects directly associated with our work and applicable to Connecticut patients. On recommendation of the scientific committee, grants-in-aid will be awarded by the lay businessman.

It is apparent from this outline that an aroused interest in the cancer program as well as the prospect of increased funds will touch the life and practice of the whole medical profession. It is true as well that the service provided to the patient will make some change in our clinic program as it has been operated up to the present. The good ultimately accomplished will depend to a great degree on the conscientious effort of the medical practitioner.

# TROPICAL DISEASE AND THE CONNECTICUT PHYSICIAN

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In normal times, the physician of the temperate zone has regarded the so-called tropical diseases as basically foreign to his immediate practical interests. Now, however, he is well aware that many of his colleagues and townspeople have been transplanted into a world of prostrating heat and humidity, of plaguing insects, of malaria, dysentery, and filariasis. We propose to consider tonight some of the ways in which the impact of these infectious diseases may affect his own practice.

While the term "tropical medicine" is glibly used, it is not as readily defined. To say merely that it is the medical practice of the tropics is surely to beg the question, since there is no unanimous agreement on the term "tropics," some preferring a strictly geographical interpretation, others insisting on one of thermal limits. Furthermore, many of the so-called tropical diseases by no means are confined to

*Presented at the 155th Annual Meeting of the New London County Medical Association, Waterford, Conn., April 5, 1945*

the tropics however defined, but are actually or potentially cosmopolitan. We well know that malaria flourished in Southern New England in the 19th century, that yellow fever and cholera were raging far north. Amebic dysentery was first described in 1875 by Lösch in St. Petersburg, Russia. Recently Stoll[22] found an incidence of 23 per cent of helminthic infestation of the intestinal tract—so often thought of as characteristically "tropical"—in a group of school children of Princeton, New Jersey.

By tacit consent, then, certain diseases are labelled "tropical" because they flourish best under the conditions of heat and moisture prevailing there, aided and abetted by a human host all too often endowed with lowered resistance, living at a low economic level under totally inadequate sanitary conditions.

The most important tropical disease for which the Connecticut physician must be on the alert is malaria. The influx of malaria with returning personnel is not a remote possibility, but a fact. From 1928 through 1942, the average number of cases reported annually to the Connecticut State Department of Health was 5.5.[10] In 1943 there were 19 cases, in 1944, 63, and for the first 81 days of 1945, 31 have already been reported.[15] With a few doubtful exceptions still under investigation, all of these were contracted outside the continental limits of the United States. Since the present rate of return of troops is a trickle to what will take place with demobilization, one may reasonably expect a not inconsequential introduction of malaria into our state and the country at large to add to the existing endemic focus in the southern states.

The physician, then, must first be prepared to recognize acute malaria and to treat it effectively. He may profit by the extensive experience of those who have recently had ample opportunity to study this disease, and particularly the dangerous falciparum infection, in which the asexual cycle proceeds in the visceral capillaries rather than in the peripheral blood. These have been impressed by the frequent departure from the conventional pattern of recurring chills and fever, and have found that the infection may assume many disguises. It may be silent, or simulate respiratory tract involvement, or gastroenteritis, myalgia, or especially some central nervous system disturbance.[11,18] Often, swift disaster overtakes the patient while the physician is gathering his scattered diagnostic wits. The prophylactic administration of atabrine or quinine does not prevent invasion by the plasmodia, and when the seemingly healthy veteran discontinues the drugs, a clinical attack may follow. How critical this may be, has been recently emphasized in the experiences of personnel returning by plane from endemic zones.[18] Only the most energetic therapy, including parenteral quinine or atabrine, may prevent a fatal outcome.

But the physician of the United States must expect more extensive experience with malaria than that afforded by the management of the acute case shortly after return from abroad. Its impact on his practice will be far greater since malaria is a chronic, relapsing disease, with variable periods of latency. The usual course will differ for the various types of infection, and is influenced by a host of other factors. Untreated falciparum malaria usually runs its entire course within one year, tertian seldom lasts more than three years, while quartan may persist for 6 years and longer.[2] Exceptional cases are on record of relapses after as long as 20-37 years, particularly with quartan infection. Atabrine has won its place as a satisfactory substitute for quinine, once its pharmacology had been worked out, and the need of larger initial doses has been demonstrated if adequate blood levels are to be achieved. It is now held that proper therapy of an acute attack of falciparum malaria may eliminate the infection. Similar therapy of an acute attack of tertian or quartan malaria, will terminate the acute episode, but will not avert subsequent relapses. It seems, therefore, that the major problem of chronic malaria transplanted to the temperate zone will be the tertian and quartan varieties.

Since gametocytes are not long in appearing in the blood stream of patients with chronic malaria, the epidemiologists are much concerned with the question of possible secondary spread in the local population. This has been known to occur, as in the disastrous outbreak of malaria in Russia after World War I.[5] Some uneasiness on this score may be felt here since there are 5 species of Anopheles mosquitoes indigenous to Connecticut, including the important malaria transmitter, *A. quadrimaculatus*.

Finally, with the shrinking of world distances through the extraordinary increase in the speed of travel, notably by air, a concern has been expressed over the possibility of the introduction into the United States of more efficient malaria vectors. The major catastrophe which struck Brazil following the chance introduction of *A. gambiae* from Africa has given this hazard great weight.[21]

However, opposed to the spread of malaria into the temperate zone of the United States are power-

ful natural and artificial barriers. The cool climate does not furnish a particularly favorable "ecological niche"[8] for many of the best malaria transmitters. Then, too, the plasmodia cannot develop in the mosquito for much of the year, since the falciparum parasite thrives best at a temperature of 86° F, the quartan at 72, and the tertian at 77.

The artificial barriers are becoming increasingly effective. The use of repellents, of insecticides like D.D.T., and all the other items in the bag of tricks of the malaria control officer, are doing much to reduce the incidence of infection. The first line of defense against the introduction of malaria into Connecticut really lies in the unprecedented programs of prevention and control practiced in India, China, Africa, and every other place where American troops are exposed. The second line of defense lies in the vigilance maintained over transportation facilities. The fumigation and other precautions observed on incoming planes should intercept any potential new vector. Even if a good transmitter were to break through, one is not likely to encounter here the disaster which befell Brazil with the arrival of *A. gambiae*. The magnitude of that calamity was not insignificantly favored by the universal poverty and famine of the affected people, and the lack of adequate facilities of prevention and therapy.[21] As a third line of defense, is the check-up of the men returnnig from the tropics, in order to intercept any silent infection. A fourth, and vital line of defense lies in the local anti malaria measures. A program of mosquito elimination in the vicinity of military establishments and prisoner of war camps has already been undertaken, while some are envisaging for the future a far more ambitious program directed toward total *Anopheles* eradication.

The practicing physician's role in the malaria problem is a dual one. Upon his alertness depends the diagnosis and proper therapy of the individual case. He is, further, important in the program of prevention, since he is in a position to single out and control the carriers who might make secondary outbreaks in the community possible.

The dysenteries rank only second to malaria as an outstanding scourge of the tropics. What with the high incidence of disease among the natives, high carrier rates, the use of night-soil as fertilizer, polluted water supplies, inadequate general sanitation, and an abundance of flies, the opportunities for infection are endless. Newcomers are particularly vulnerable, and the armed services, in spite of all precautions, are notoriously susceptible. In a recent report from the Middle East, over one-third of 13,542 hospital admissions were enteric infections.[4] One traveller recently admitted to nine bouts of diarrhea or dysentery in the course of a six months stay in the Orient.

The Salmonella infections are for the most part self-limited and acute, and while with some strains a chronic carrier state may be established, this is relatively uncommon.[1] Many of the Shigella dysenteries may similarly run an acute course, which may be favorably influenced in some instances by sulfonamide therapy. Because of the wide prevalence of these infections in the tropics, a rise in the carrier rate is anticipated with the return of the troops. Admittedly, both Salmonella and Shigella are already widely dispersed in this country. Thus, Felsen stated that between 1933 and 1937 there were no less than 700,000 cases of Shigella infection in the United States.[23] In Connecticut, there are on record 52 to 186 cases of bacillary dysentery annually during the past ten years.[15] This probably represents a very small fraction of the actual total incidence, since in a recent study, it was found that of 380 persons whose fecal cultures were positive for Shigella, only two were under the care of a physician.[9]

The highest incidence of bacillary dysentery reported in Connecticut occurred in 1943, with 186 cases, while the rate for 1944 was not remarkable.[15] If the physician is on the lookout for the Shigella regardless of how benign the clinical picture may appear, and applies the newer refined techniques for the more certain isolation of these organisms one need not anticipate too great an increase in this infection in a state maintaining high standards of sanitary control. It has been suggested, however, that the practicing physician might encounter an aftermath of increase in chronic shigellosis. This most distressing state, not unlike chronic ulcerative colitis, perhaps complicated by arthritis, iridocyclitis, achlorhydria, or polyneuritis, may tax all his skill and clinical acumen, for the difficulties of diagnosis are great, and those of therapy almost insurmountable.

The *Endameba histolytica* ranks with the *Shigella* as a major cause of infectious enteric disease. It frequently leads to mild disease in the temperate zones, and this perhaps acounts for the general lethargy towards this problem in the northern states, where there is a reputed incidence of 5-10 per cent cyst carriers. This indifference—somewhat jarred, to be sure, by the violent Chicago outbreak of 1933—is not shared by the physicians of the southern states

nor by those practicing in the tropics, who are often confronted by a much more fulminating clinical picture.

The severity of amebiasis in the tropics is thought to be related to a lowered state of resistance of the human host and possibly to generally higher doses of infecting cysts. The evidence is not sufficient to prove that the strains associated with severe disease are necessarily more virulent. While one cannot claim, therefore, that imported amebiasis will be more severe, one may expect a higher incidence with the influx from the heavily infested tropical foci. Epidemic outbreaks are uncommon, but with a high carrier rate, the sporadic incidence of clinical disease may be expected to rise. Amebiasis is now recognized as a chronic, relapsing disease, which may be silent for long periods of time, may simulate peptic ulcer, gall-bladder disease, appendiceal pathology, or functional disturbances. The diarrheas and dysenteries constitute only a fraction of the picture—some patients, indeed are constipated, or have alternating constipation and diarrhea.[6] Since any cyst passer is believed to have some tissue invasion, he may at any time develop clinical manifestations. In the face of a likely rise in these cases,the practicing physician should increase his index of suspicion for amebiasis in many of the atypical gastrointestinal pictures which he so often encounters. Systematic therapy with a suitable oxyquinoline derivative, such as diiodoquine, may free the patient completely of cysts, save him from future distress, and at the same time help break the infection chain. The particularly treacheous complication of amebic hepatitis and abscess of the liver may also be thereby averted. The diagnosis is often difficult, the signs may at first point to the thorax, there may be no history of associated or past diarrhea or dysentery, and no amebae may be present in the stool. When a diagnosis of amebic abscess of the liver is finally established on clinical grounds, perhaps supported by a positive complement fixation test, the lesion is always threatening to the patient and requires most exacting therapy with aspiration and emetine as the chief means of effecting recovery.[20]

Like malaria and amebiasis, filariasis runs a chronic relapsing course. Hence, when it became certain that some American troops contracted the infection, and coupled with the fact that it may be transmitted to man by some 56 different species of mosquitoes, concern was felt over its introduction here. The clinical findings in the infected men have not progressed beyond the early stages: noteworthy were the ready fatiguability and increase of local symptoms on exertion, the lymphangitic and erysipelas-like erythemas with fever, the lymphadenitis, and the enlargement, pain and tenderness of the scrotal contents.[12,14] Newer methods of diagnosis are being developed, but progress in therapy is slow, though anthiomaline is said to reduce the number of circulating microfilaria.[3] The ultimate prognosis is a source of considerable anxiety for the patient, since he has seen the far advanced monstrous lesions among the natives of the tropics. However, some students of the disease hold out the hope that elephantiasis and other late obstructive phenomena may never develop in these men, since the exposure of the Americans has not been sufficiently heavy and prolonged.[19] The physician has been urged to give his patients every assurance of ultimate recovery, lest his difficulties become more psychiatric than lymphatic. As for the spread of filariasis here by the bite of microfilaria-bearing mosquitoes, it is noteworthy that an old focus of filariasis in the United States at Charleston, South Carolina, has died out. Also arguing against wide dissemination of the microfilaria among native mosquitoes is the fact that at least so far, the peripheral blood of the patients has been negative for microfilaria, or has rarely shown them in very small numbers.[12,14] Should they occur later, further safety may be sought in pursuing more vigorously local anti mosquito campaigns.

The diseases which have been considered by no means exhaust the field. Of great importance to the Connecticut practitioner may be such diseases as schistosomiasis and kala-azar, since they both are insidious and chronic, and may become his responsibility for months or even years. It has been argued that these infections would not spread further in their new environment, since the necessary intermediate vectors do not exist here. How misplaced such confidence may be is evident from the very recent successful demonstration that a native snail, *Tropicorbis havanesis* may act as the intermediate host of *Schistosoma mansoni*.[7] The possibility that native sandflies may take the place of the intermediate hosts of kala-azar is now under investigation. The occurrence of hemoptysis and other pulmonary symtoms in a veteran of the tropics may be due to paragonimiasis,[17] or even to the peregrinations of the ascaris or strongyloides worms. There may be more of cutaneous mycoses to handle, since these have been particularly obstreperous in some theaters of operation. One medical officer just back

from the South Pacific and India explained that his men tried to avoid these disabling mycoses by frequent ablutions in the local streams, but on stepping on the shady banks, picked up hook worm. Not to be forgotten is the high prevalence of some diseases in the tropics which are common enough here, such as tuberculosis and the venereal infections. On the other hand, it does not seem that many Americans will contract leprosy,[13] which is today almost entirely a tropical disease. However, as Kellerberger has pointed out, the rigors of war may activate silent cases coming from some endemic focus in the United States.

The short duration of an acute infectious disease is no longer assurance that it may not be transplanted here from a distant land. The speed of air travel has now made it entirely possible for a patient to arrive here during the incubation period of yellow fever, dengue, or small pox. Careful control over passengers, general vaccination programs, and other steps are relied upon to avert such an occurrence.[24] The usual quarantine precautions and immunization may continue to bar cholera, plague, and typhoid.

The already overburdened practicing physician of Connecticut can hardly be expected to become an expert in parasitology and tropical medicine over night. His success in handling these problems will depend on his past experience and, as always, on keeping the possibility of these unusual infections in the back of his mind. He may find it helpful to incorporate as an irreducible minimum in his routine the following program:

1. Everyone coming back from an endemic zone should remain under suspicion of malaria until this is clearly ruled out. Search for the plasmodia on thin and thick blood smears should not be omitted no matter how bizarre the clinical picture.

2. Similarly, the stools should always be examined for protozoa, ova, and parasites.

3. A careful geographical history should be taken. At times, this may specifically point to a particular disease, especially after the extensive data on the geography of disease which is now being compiled becomes generally available. More often, it may just direct his thoughts generally to "tropical disease" as the possible diagnosis.

Since the final diagnosis often leans heavily on laboratory data, it is the physician's task to become familiar with both the range of usefulness as well as the limitations of these procedures. It is the physician's, and not the laboratory technician's responsibility to appreciate that a thick blood smear may be 30 times as effective in demonstrating plasmodia in minimal numbers as a thin smear. He too must be alert to the possibility that a smear may be entirely negative on one day, and yet overwhelmingly positive on the next, an instance of how, to repeat Lindsay's oft-quoted remark, "a negative blood slide has sent many to the grave."[16]

In conclusion, we do not believe that any major or permanent infiltration of tropical disease is likely here. The natural barriers against many of them are powerful, and the ever increasing tempo of intelligent, world-wide preventive medicine and public health control should go far in checking any such trends. One cannot, however, deny as possible the influx of tropical disease upon demobilization, nor should one overlook the fact that with the likely further expansion of air travel after the war, the interchange of diseases the world over may be facilitated. The brunt of the foreign and remote diseases which had hitherto been borne by the great sea ports, may in the future be more equitably shared with communities throughout the states. Perhaps, by way of compensation, a broader understanding of the many complex problems of host parasite relationships among the tropical diseases may shed light on some of the many unsolved problems of temperate zone medicine.

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# CHEMOTHERAPY OF NASAL SINUS DISEASE

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Chemotherapy, a word with wide implications, has now been given a restricted meaning to describe the use of those chemical substances that have a selective bacteriostatic action. The term is understood to include those biochemical substances recovered from the growth of molds, fungi and bacteria that have bactericidal or bacteriostatic qualities. Such a classification will include Arsphenamine, the sulfonamides, penicillin, tyrothricin and patulin with the list left open for the inclusion of all the undiscovered products of the growth of molds and fungi that are found to be lethal to pathogenic bacteria.

The use of these agents to control infections of the nasal sinuses has been taken up with high hopes by both physician and patient because of the spectacular results obtained from their use to control infections in other parts of the body. The physician, in his eagerness to offer something in the treatment of sinus infections that would be better than nose drops, cold inoculations, oral vaccines and short-wave diathermy, welcomed the new drugs with unrestrained enthusiasm.

In our approach to the problem of nasal sinus disease, full value must be given to the importance of the common cold, a virus infection, self limited in its duration and recognized by the signs and symptoms in the nose as sneezing, congested nasal membranes and excessive discharge of nasal mucous. A mild pharyngitis with a sensation of dryness in the nose and throat are part of the picture.

A bacteriological study of the nose of most people will show, at all times, the presence of potentially pathogenic bacteria. Some, or many of these organisms are the perennial guests in the nasal cavities of many people. With the invasion of the nose or nasopharynx by the virus of the common cold, these bacteria at once take on great activity with increase in numbers and virulence. This step in the sequence of events is the important but unexplained phase, causing the complications attendant on or following an acute coryza. It is probable that the presence of the cold virus in some way activates the normal bacterial flora of the nose and with their increase in growth and virulence we observe the expected extension of the infection to the nasal sinuses, the middle ear, the bronchial tree or even a contamination of the blood stream. It is at this point in the progress of the infection that bacteria in great numbers can be recovered from the nose and nasopharynx. It may be a mixed growth of organisms or what is more usual, there will be a predominance of a single type.

Because of the spectacular success attending the local use of the sulfonamides in open wounds and surgical cavities, physicians seized on these drugs for local application to the nose in cases of infec-

*Presented at the 152nd Annual Meeting, Connecticut State Medical Society, Bridgeport, May 4, 1944*

tions of the nasal sinuses, overlooking the fact that the unbroken mucous membrane of the nose and sinuses did not offer the same favorable setting for the action of the sulfonamides as did the raw wound surface produced by trauma or surgical operation. It is apparent that their enthusiasm outran their sober judgment and as a result the drug market was flooded with drops, sprays and powders medicated with the sulfonamides and recommended to be instilled, sprayed or insufflated into the nose for the treatment of sinus infections. Many favorable clinical reports were published by reputable observers on the effectiveness of this type of medication.

In nasal sinus disease, the lining membrane of the nose and sinuses are edematous and congested causing a restricted airway and changing the sinuses into closed cavities. Medication instilled into the nose does not enter the sinus cavities and cannot come in contact with the disease organisms that are the source of the infection. Nothing will be accomplished by destroying bacteria in the nasal cavity when the site of the trouble is in the sinuses now closed off by the engorged and edematous membranes of the nose. It is possible that the favorable results that have been observed following the local use of the sulfonamides in the control of sinus infections has been due to the addition of vasoconstricting drugs that are added to the medication. The shrinking of edematous nasal mucous membranes is an effective method of treatment of nasal sinus disease and it is difficult to evaluate the respective value of the sulfonamides and vasoconstricting drugs when the two are used in combination.

Since it was determined that nothing could be accomplished by destroying bacteria in the nasal cavity when the infection was in the nasal sinuses, completely shut off by edematous membranes, it was planned to bring the sulfonamide drugs into direct contact with the offending bacteria at the site of the infection. The displacement method of creating a vacuum in the nose and by the release of the vacuum to allow the medicated fluid to flow from the nose into the nasal sinuses is an accepted method of treatment of sinus disease. It has never been a satisfactory method of treatment in my hands. Because of the favorable reports returned by many reputable observers who use this method, a review of this mode of treatment was carried out.

A number of contrast agents were used in these experiments to determine how much of the opaque media could be made to enter the sinuses by the displacement method of producing a vacuum in the nose. Lipiodol, diodrast and a suspension of bismuth were used in turn as contrast media and the results checked by x-ray film examinations. It was observed in this series of experiments with contrast media that in most of the subjects the spenoid sinuses were well outlined. In a moderate number, the maxillary sinuses showed some of the contrast media. In a limited number, some of the opaque media could be seen in the region of the ethmoids. In none of the films was any of the contrast media seen in the frontal sinuses.

I was convinced after this review of the displacement method that no reliance could be placed on this mode of causing medication to enter the sinuses by creating a vacuum in the nose. Again I think that the favorable results reported from this treatment have been due to the preliminary shrinking of the membranes by vasoconstricting drugs which are, as a rule, made use of in the displacement treatment, preliminary to creating a vacuum in the nasal chambers.

Another approach was made to the problem of bringing the sulfonamides into contact with the lining membrane of the infected sinuses. Industry has recently made use of certain surface compounds having marked wetting and penetrating characteristics. It was hoped that using these wetting agents as vehicles to carry the sulfonamides, the lining membranes and the ostia would undergo some penetration. This series of experiments was carried out with a number of cases of sinusitus of the acute type. A solution of sulfadiazine, two and one half per cent in Aerosol, a widely used wetting agent, was sprayed into the nose at hourly intervals. The patient was observed for evidence of shrinking of the nasal membranes, change in the bacteriological picture and decrease in the amount of purulent discharge. None of these favorable changes were observed, and the promise held out by these wetting agents as vehicles to carry the sulfonamides was not fulfilled. They are remarkable compounds in their action as detergent, emulsifying and penetrating agents but they do not penetrate the nasal membranes or the ostia of the nasal sinuses.

During the time of these clinical experiments when it was evident to me that the local application of the sulfonamides to the nasal cavity was not warranted by either clinical results or reason based on physical and mechanical laws, there appeared a report by Russell Cecil and his associates on their investigation of the "Treatment of the Common Cold by Sulfadiazine." Among other observations made by Cecil was that the oral use of sulfadiazine

did not shorten or alter the course of the common cold. He did note that a bacteriological study revealed a consistent reduction in the total number of organisms recovered from the upper respiratory tract, in persons receiving one gram of sulfadiazine three times daily.

Cecil in his investigations was interested only in the common cold and did not include the bacterial complications attendant on this virus infection. The marked reduction in the number of bacteria found in the nose and the nasopharynx in the course of his treatment with small doses of sulfadiazine seemed to indicate another angle of approach to the treatment of nasal sinus disease.

The opinion expressed in a recent paper on sinusitis that, "We should never resort to surgery as long as adequate progress can be made by conservative treatment," is a concise description of the wave of conservatism in the treatment of sinus infections that swept over the country 15 years ago. I think this wave did much to submerge what should have been a serious effort to perfect the surgical treatment of sinusitis, infections that have all the characteristics that we recognize as making up a surgical infection. The crest of this wave brought in all the wreckage of conservative treatment; nose drops, spraying solutions and diathermy.

I believe that an infection of the nasal sinuses is a serious malady, especially in young people. I find that such infections are prone to return each year or more often and are the cause of repeated and prolonged periods of disability. I find that patients suffering from acute sinus infections dismiss themselves from treatment when symptomatic relief is obtained and long before signs and symptoms of the infection have disappeared. These patients are almost certain to have recurrences of the infection which is only a reactivation of the original infection that was never cured.

It is my opinion that acute infections of the nasal sinuses, in any age group, require prompt and intensive treatment that should be continued to the point of complete cure when such a cure is possible. It is for this reason that I make use of the newer chemotherapeutic agents, in adequate doses supplemented by surgical measures when these are indicated. Conserative treatment of sinus infections, under my direction, has resulted in some relief of disagreeable symptoms but with recurrent attacks that gave displeasure to both patient and physician. These are some of the reasons I offer for the early use, in full doses, of sulfadiazine in the treatment of nasal sinus infections.

Not all infections of the nasal sinuses require treatment with the sulfonamides. Always, we have in mind that the sulfa drugs are highly toxic chemicals. We know that patients may become sensitized to the sulfonamides and, while toxic symptoms may not appear during a course of treatment, it is possible for them to manifest themselves in a violent manner when these drugs are given for some succeeding illness. Our decision to use the sulfonamides in the treatment of sinus disease will depend on the value of these highly efficient drugs as weighed in the balance against the menace of toxic reactions and the danger of creating a state of sensitivity in the patient. It is well that we review our knowledge of the action of the sulfonamides from time to time in order that our treatment does not become a meaningless ritual but rather specific therapy directed against a thoroughly understood pathological condition.

Before instituting the sulfonamide treatment of sinus infections, the surgical features of the disease must be estimated. At this point, we will remember that the sulfonamides are ineffective in the presence of pus or necrotic material. We have learned that the sulfonamides are of no value in the treatment of abscess pockets or where the infection is closed off by barriers created by thrombosed vessels. Our experience in lung abscess, surgical mastoditis and chronic osteomyelitis bear out this observation. The rhinologist will apply such surgical measures as are required to open up diseased sinus cavities preliminary to the oral use of the sulfonamides. If surgical measures are followed, the cavities produced by surgical treatment will be treated locally by the highly soluble sulfanilamide crystals, keeping in mind that the cavities should not be filled with this material but rather a dusting of the outlining walls.

The time has arrived when we must put aside what we have been pleased to call the conservative treatment of sinus infections. Sinusitis is a surgical infection and calls for the same active treatment that is given surgical infections in other parts of the body. The conservative treatment of sinus infections has been timid in its approach and barren of results. It is for this reason that I make use of the sulfonamides to supplement the surgical treatment of these infections. Surgical measures are not indicated in the acute infections unless it be the breaking over of the middle turbinate bone. In cases of a chronic nature, with purulent discharge, infected lining

membrane and a sinus cavity filled with necrotic material, the surgical removal of the products of infection will permit the maximum effect of sulfonamide action by the local application of sulfanilamide crystals to the operative field and the systemic administration of sulfadiazine by mouth. This plan of treatment has enabled me to obtain marked improvement in many obstinate and long continued infections of the nasal sinuses with some clinical cures.

COMMENT

The sulfonamides are not effective as bacteriostatic agents when used on the unbroken surface of the skin or mucous membranes. It is for this reason that it seems illogical to use solutions or suspensions of these drugs for local application to the unbroken mucous membranes of the nose with the expectation that disease producing organisms that are in the soft tissues will be affected or controlled.

The oral or intravenous administration of these new chemical agents is the only means by which these drugs can be brought in contact with the disease producing organisms that are lodged in the lining membranes of the nasal sinuses. They must be used early in the acute infections, before the infected area is closed off by thrombosed vessels.

We must review our pathology, revise our surgery and integrate our knowledge of the new chemotherapeutic agents. With the proper timing of indicated surgery, coordinated with the systemic use of the new drugs, together with the application of selected bacteriostatic substances to the field of surgical operation, sinus infections of many types can be brought under control.

# AN UNUSUAL CASE OF SCORBUTUS

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FROM BABYHOOD through adolescence and adult life the standard diet for people of the United States calls for, and is almost universal in its use of, the daily consumption of citrus fruits.

Long recognized for the maintenance of health, the necessity for vitamin C has appealed to the public. In the minds of many it has assumed the proportion of a fetish. Mothers have become intensely impressed with its value to the growing child and their duty to see that the child gets vitamin C. Abundant quantities are available throughout the year at moderate prices and, because of the pleasing taste of the citrus fruits, children and adults consume large quantities. Because of this, it is most unusual to be able to report a severe case of vitamin C avitaminosis. Cases appear now and then exhibiting a moderate degree of deficiency and the cause can be ascribed to ignorance, poor living conditions, indigence, allergy, distaste, and residence in remote sections where the citrus fruits are hard to obtain; and, finally, carelessness, indifference, and a stubborn and scoffing attitude relative to the value of vitamin C.

This report is unusual because it deals with an adolescent living in a large city under favorable conditions and it brings to notice two of the causes mentioned as resulting in lack of vitamin C. First a distaste of citrus fruits, and second, the non-recognition of the value of enforcing the daily eating of the fruit or the resorting to synthetic administration.

F. M. Age 16, white male, residence Bridgeport

Chief complaint: Purple spots on extremities. Hematuria for 48 hours and bleeding from gums. Patient seen at the office December 7, 1943. Two days previously I had called at the home to make a visit on the father, who had a mild attack of influenza. At the time I noticed the boy and he appeared perfectly well. The patient came to the office as stated above and asked me what the spots were on his legs and arms. On first examination I could not determine the cause. Careful examination failed to reveal any other abnormalities. The boy was sent home and told to report the next day. He was told to eat lemon peel, bearing in mind the possibility of a blood dyscrasia or fragility and a lack of vitamin P. The next day, December 8, 1943, the patient reported again to the office with an increase in the purpuric spots, both in size and number, and reported passing what looked like blood in his urine.

Also, blood on the pillow from his mouth. The parents accompanied the patient and on questioning disclosed that the patient had persistently refused to eat fruit or vegetables because he did not like them. He ate plenty of meat, soup, cereals, pastry, milk, and consumed large quantities of pop sodas, principally cola drinks.

Examination of urine disclosed a large number of red blood cells. The gums were soft and spongy and bled easily on brushing them with swab. The boy was fairly well developed but very tall for his age, 6 feet 1 inch, weight 145 pounds, rather pale and listless looking. He was sent to the hospital for a complete check-up December 8, 1943.

HOSPITAL RECORD

F.H. Negative.

P.H. Scarlet fever at 5 years of age. Tonsillectomy eight years ago. Always healthy and active; plays basketball often. Does well in school.

Purpuric spots distributed over extremities and trunk. Several bleeding spots over gums. Heart and lungs: Clear. Abdomen: Slight tenderness in right upper quadrant.

Positive Rumple Treder test.

Blood: Hemoglobin 95, RBC 4,960,000, WBC 7,750. Qualitative normal.

Urine: Albumin 4 plus. Sugar: 0. Blood present in quantity.

Wasserman and Kahn negative.

Temperature, respirations and pulse normal.

Patient was put on antiscorbutic diet and given daily intravenous injections of 500 c.c. 5 per cent glucose and ascorbic acid 100 mgs. Also given orally 2 gelseals of multicibrin Lilly daily.

Purpuric spots disappeared after 7 days of treatment, gums became firm, and all bleeding ceased. Urine showed only rare RBC on December 16, 1943, and patient was discharged on antiscorbutic diet and multicibrum and pulvules of Cevalin. No recurrence of the scorbutus.

COMMENT

Undoubtedly physicians will see not infrequently scorbutus in varying degrees of severity appearing among the returned veterans. The Army and Navy hospitals are in full knowledge of the presence and the deleterious effects of avitaminosis and also of their responsibility to treat such immediately on their reception by the hospital. The armed forces have been provided with prophylactic doses or rather rations with sufficient amounts of almost the entire list of vitamins. They also have entire elucidation as to their value, but returning prisoners, personnel secreted on isolated islands, or wherever they may be in hiding, will come back in rather desperate need of vitamins. All such will receive governmental care for a period. On return to civil life, however, the bankruptcy in vitamins sustained over the periods of incarceration or isolation probably will be reflected in symptoms of avitaminosis which the patient and the physician may not readily recognize promptly.

It is recommended that veterans returned to civil life when seen by physicians be advised to eat citrus fruits or be given synthetic vitamin C for a given period as a prophylactic in cases where suspicion of vitamin C deficiency is present, even if deficiency is not demonstrable.

# THE PHYSICAL EXAMINATION AT THE INDUCTION STATION

## (New Haven Recruiting and Induction Station, New Haven, Connecticut)

CHARLES C. VERSTANDIG, *Major, Medical Corps, New Haven*

NO DOUBT many of the readers have often wondered as to the efficiency and manner of operation of the Medical Section of the New Haven Recruiting and Induction District, located at the Orange Street Armory, New Haven, Connecticut.

An attempt will be made in this article to familiarize the reader with the physical examination section of this Armed Forces Induction Station.

Through the operations of the Selective Service System, the major portion of manpower comprising our Armed Forces have been processed. This system set up the basic mechanism for registration and vests authority to those who are appointed to administer its provisions. Through the four years in which this system has functioned, wise planning has made for a smooth functioning organization. Experience

gained from World War I has furnished us with valuable information and data in the present plan of selection.

Mobilization Regulations as set forth by the War Department have been the criteria for determining the acceptability of men for military service. One must realize that it is of major importance to exclude from the armed forces men who are liable to break down early under the stress and strain incident to military service. For this reason a careful and complete physical, mental and psychological examination is necessary, and must be performed according to specific directions, embodying standards for acceptance.

The New Haven Recruiting and Induction Station was set up in the Orange Street Armory on the 1st of March, 1943. Prior to its official opening, clinicians, dentists, ophthalmologists, orthopedic surgeons, otolaryngologists, psychiatrists, roentgenologists and surgeons were necessary to aid in comprising a satisfactory examining team.

In this direction, recognized specialists in their respective fields were contacted and designated as chiefs of sections. The chiefs of sections in turn secured additional competent physicians to work in their sections. At this station we are fortunate to have diplomates of the various boards serving as examining physicians.

A psychologist and his department constitute a separate section of the examining team. Psychometric studies are conducted on all selectees who have not completed the 12th grade of school. The psychologist, an officer in the Adjutant General's Department, also conducts the Neuropsychiatric Screening Adjunct. The psychologist rates the selectee's ability to learn, and renders an opinion as to the registrant's capacity for intellectual cooperation.

Photoroentgenographic examination of the chest is an integral part of the examination. The experience gained in World War I showed that it was impossible to screen out early cases of pulmonary tuberculosis by means of the stethescope.

The fact that the writer had the opportunity to be ordered to active duty in the summer of 1940, saw the Army grow, became familiarized with Army regulations, served as executive officer of a station hospital, held sick call, served as roentgenologist and detachment commander, served in an overseas theatre—all have aided, no doubt, to determine the acceptable caliber of men require to make good soldiers. Such a background of experience is an asset in the final judgment as to acceptability of men for military service.

We are quite fortunate, in this state, in having such an excellent State Health Department. All men rejected for complications of venereal diseases, such as severe urethral strictures, cardiovascular, cerebrospinal and visceral syphilis, are regularly reported to the State Health Department for follow up treatment. We also advise the State Tuberculosis Commission of every case rejected at this station for pulmonary tuberculosis.

The actual physical set up of our Induction Station can well be compared with a "production line." At one end, the registrant enters the station to later emerge classified as accepted for either general military service, or limited military service (below the general service level), temporarily rejected because of a remediable defect, or rejected by the armed forces.

At the beginning of the "line," that is, prior to the beginning of the physical examination, all selectees are interviewed, regarding the existence of disease, history of disease, enuresis, convulsions, head injuries, asthma, hay fever, operations and such pertinent data which might have bearing on determining the man's acceptability for military service. Those registrants who do not meet the minimum educational requirements are further tested by the psychologist and classified. All registrants are given the Army NSA (Neuropsychiatric Screening Adjunct). Every registrant who enters the station on a delivery list submitted by the respective Selective Service Local Board is given a complete and thorough physical, mental and necessary psychologic examination.

At this station, sections (examining booths) are established for photoroentgenography, pulse and temperature, urine analysis and necessary blood examinations (vena-puncture, smears, bleeding or clotting time, as well as accessory laboratory tests), dental examination, ear-nose-throat, cardiovascular examination to include blood pressure determination, skin and endocrine system, general surgical and orthopedic, eye, psychiatric, psychological, and, finally, the Joint Examining Board, which finally determines the acceptability of a registrant based on the findings of the line of competent physicians and surgeons. The Joint Examining Board consists of an Army and Navy Medical officer, which decides upon the acceptability, as well as physical classification

of a registrant. At the Joint Examining Board, each registrant is further questioned pertaining to possible defects otherwise unnoted, before final disposition is made. Throughout these examining booths are found posters which remind the registrant to bring to the attention of the examining physician any defects which he may have, such as: "Do you have a running ear?"—"Do you have asthma or hay fever?", etc. The regulations and standards for physical examinations for acceptance, are set forth in Mobilization Regulation 1-9, dated 19 April 1944, with the respective changes to same.

In this State, we have an excellent confidential system through which medical certificates and documents, pertaining to Selective Service registrants, are cleared. Through such a system we are able to accept certificates and hospital records which we know are authentic.

The work in the Medical Section of an Induction Station is quite stimulating as well as educational. At such a station, an examiner has the opportunity to note and examine every conceivable type of acquired or congenital deformity, sequelae to disease and injury, as well as the various degenerative processes occurring in disease and injury. The examining teams deserve all the credit for the efficient and conscientious manner in which this type of work is performed.

During such an examination, all five senses are utilized constantly, during the course of a day. Diagnostic aids including the ophthalmoscope, trial frames and lenses, laryngoscopic mirrors, and radiography are only a few of the methods utilized.

An analysis of the major causes of rejected registrants, reveals that psychiatric diagnoses comprise the largest percentage. It has been noted that many registrants with gastro-intestinal complaints which are psychosomatic in character are due to psychoneurosis and constitutional psychopathic states, rather than due to organic gastro-intestinal disease. Roentgenographic examination of the gastro-intestinal tract is used to eliminate organic pathology.

Ear, nose and throat examination reveals that there is a relatively high frequency of perforated drums, as well as chronic otitis media. In all probability, a certain percentage of these conditions is due to a delay in operation for recurrent otitis media, which often follows mastoiditis in childhood.

We have found that many cases of tachycardia are associated with fever. It has been noted that registrants with a temperature of 99°F often reveal a rise in pulse to 110-120 per minute. We have also found that long trips to the induction station, rush and speed in examination, smoking prior to entry to the examination section, consumption of beverages, all combine to produce an unstable circulatory mechanism. At this station, we have the registrants sit down while their temperature and pulse are determined (every registrant has his temperature recorded if he reveals a pulse of 100 or over).

A survey of the rejection rate for reinfection pulmonary tuberculosis at this station reveals approximately .5 per cent of the registrants are disqualified for this cause. Every case rejected for pulmonary tuberculosis is reported to the State Tuberculosis Commission for follow up.

We must not repeat the experiences seen in the post war era following World War I. Therefore, it is of utmost importance that registrants who present definite evidence of mental or nervous disorders be rejected and that those selectees with tuberculosis (pulmonary) be recognized early and rejected at the induction station. It is the task of those of us, charged with selection of men for the armed forces, to prevent a recurrence of the post war experience of World War I. It is certain that a vast number of cases of disabilities will develop under the strain of combat.

The experience gained from the examinations of such large groups at induction stations suggests several research problems in the future. Some such research problems may well be: (1) Reduction of illiteracy; (2) Correction of inadequate housing; (3) Compulsory action in regard to the reporting of venereal disease; (4) Control of prostitution; (5) Study into the cause of hypertension; (6) Correction fo defective vision in school children; and (7) Compulsory annual physical examinations.

Let us, in conclusion, direct our efforts towards the maintenance and preservation of the health of our nation and its populace. Therefore, let our motto be "Maintenance of physical and mental fitness is essential to the defense of liberty."

# DANIEL WEBSTER AND THE HAY FEVER

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*Shall our state legislature be allowed to take that which is not their own, to turn it from its original use, and apply it to such ends or purposes as they, in their discretion, shall see fit? Sir, you may destroy this little institution; it is weak; it is in your hands! You may put it out, but if you do, you must carry on your work! You must extinguish, one after another, all those great lights of science, which, for more than a century, have thrown their radiance over the land! It is, sir, as I have said, a small college,—and yet there are those who love it . . .*

THESE words spoken with all the fire of a passionate soul before the Supreme Court of the United States on a March day in 1818, suddenly lifted a vigorous young Congressman from New Hampshire to high fame and closed the argument that led the Court to a decision in the case of Dartmouth College vs. Woodward, that has been so frequently quoted that it has become almost a part of the body of the law itself, which provides that a charter is a contract entered into by a state, and that no legislative act can impair its integrity.

Years later a dropsical old man lay dying in an architecturally ambiguous house not far from Plymouth Bay. He was propped on pillows so that his dimmed eyes might see the flag of his country kept flying at the masthead of his small yacht anchored in an estuary. Just before the end, in a mentally clear moment, and unforsaken by his fine sense of drama he said: "Have I—wife, son, doctor, friends, are you all here? Have I, on this occasion, said anything unworthy of Daniel Webster!" And so there closed one of the great careers in American history.

This was Black Dan, even now a fabulous politician and orator around the campus of Dartmouth College. This was Dan'l, ardent lover, whose courtships are the basis of a sweetly romantic novel, and who at the height of his fame defended himself against a charge of adultery. This is Mr. Webster, sagacious guide to the nation's financial policy, who was perennially on the verge of personal bankruptcy; twice a potential candidate for the presidency of the United States; Senator, and Secretary of State;—by many called the country's greatest jurist, by others a Magnificent Failure.

When the National Hall of Fame was established in New York City in 1900, Webster received an equal number of votes with Abraham Lincoln for the position of the second most famous American. After Washington and Lincoln there has been no character in American history about whom more has been written, and it might seem superfluous to add to the great wealth of material that is readily available. There is, however, a phase of Webster's life which none of his biographers has thoroughly considered, no doubt because from their point of view it was of too trivial a nature in comparison to the sequence of high events that filled his years. One biographer was aware of this influence in Webster's life, but did not feel qualified to interpret its significance, and a study of Mr. Webster's experiences with hay-fever and the possible effect that it had upon his career has been more or less neglected.

John Bostock, a physician of London, first described the summer catarrh in an article in the *Medical and Surgical Transactions* in 1819, John Elliotson suggested the relationship between the disease and pollen in 1831, and Philip Phoebus confirmed earlier observations in his papers in 1862. The disease that was described by all of these contributors was the spring type of pollinosis, which is most often caused by grass pollens. Ragweed does not grow in England, and the distinction of recognizing the cause of the autumnal type of the disease belongs to an American, Dr. Morrill Wyman, who first described it in 1854 in his lectures in the Medical School of Harvard University, his description being

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*Presented before the Beaumont Club March 12, 1937*

rawn from his personal experience. In May, 1866, Vyman's observations were reported before the lassachusetts Medical Society, and in 1872 he pub-shed his book *Autumnal Catarrh* which is deserving a high place among the classical descriptions of sease, and in which he recounts the ingenious expe-ment of 1870 by which he established the relation-ip between ragweed pollen and the catarrh. It is ir to state, however, that with characteristic Bos-n elegance, Dr. Wyman chose to designate the ant as Roman Wormwood and not Ragweed.

Fortunately for history, Mr. Webster's case was viewed by Dr. Wyman, and in Wyman's written servations and in Mr. Webster's extensive corre-ondence, the enquirer finds a rich field for ex-oration.

The earliest evidence of Mr. Webster's suffering om this affliction was in 1832, when he was fifty ears old, which is an unusually late period in life r the symptoms to appear; in fact, it is at about at age that the severity of the disease often begins wane. Wyman is authority for the statement that e symptoms first showed themselves in 1832, but far as I am able to discover, there is no reference it in Webster's correspondence at so early a date, d, indeed, it is possible that for the first few years its occurrence he considered it to be a common old. There is a collateral letter in September, 1834, which a colleague who had recently opposed Webster in the court-room, wrote to a friend re-arking upon the fact that Mr. Webster was suffer-g from a hard cold, and was very irritable. During e years that follow there are many references to e disease in Webster's correspondence. The symp-oms occurred annually about the 22rd of August d ended about the first of October. On September 3, 1838:

"My head and eyes are not in the best condition. raveling against a strong wind has brought on my old badly, and today I am not well. The cold, or nfluenza, with which I am lately visited, is likely rom former experience, to last some weeks, and uite disable me from public speaking."

The attack of 1845 seems to have been earlier than sual. In that year on August 17 he wrote:

"Marshfield, August 17. I have been more or less nder the influence of my incurable catarrh. Some ays I have felt quite discomforted. Now it seems a ttle better. The paroxysms are not so frequent, hough two days ago I had a very bad forenoon. It ame on in a moment, and went off, when it did go, just as quick. Some days I feel quite well, and can keep out without inconvenience, if the weather be fair, on other days I cannot go out at all, fair or foul. Last Thursday was fair weather. I went over to the Gurnet and caught some fish and felt well all day. Since then my catarrh has been continuously quite severe. I hope it will soon begin to taper off."

In a letter of August 15:

"In seven days I shall begin to sneeze and blow my nose, and the first week the catarrh is usually most severe. [On the 12 of September:] I use the confiding hand of another to write you a short letter, my eyes holding out to perform a small part of the duty expected of them every day. I am in the midst of my periodical catarrh, or hay-fever, or whatever you wish to call it. I read nothing, and hardly write anything but signatures. The disease is depressing and discouraging. I know there is no remedy for it, and that it must have its course. One misfortune is, I cannot take, even in the smallest quantity, the common remedy, opium. It produces loss of appetite and great prostration of strength; but since the event of last week terminated, I have some little time for rest, and shutting myself up very much, I keep as quiet as I can."

In another year he wrote:

"My annual cold is now heavy upon me, weakening my body and depressing my spirits; it has yet a fortnight to run and perhaps will sink me lower than it did when strong excitement enabled me to withstand it [this was in 1850, at the time of the passage of the Fugitive Slave Law]. I have lost a good deal of flesh and you will think me thin and haggard. I have had little sleep, not four hours a night. [On October 14 of the same year:] Wednesday I came down to my house, a good deal sick, and have hardly been out of doors from that day to this. My catarrh has held on uncommonly, and for three or four days last week I was quite ill with it, so much so that I called in a physician. Very sensibly he recommends nothing but rest, patience and herb teas. It is usual enough for the disease in its last stages to assume the form of a kind of asthmatic cough. This I have had, and hope I am nearly over it. In such a day as this, a north east rain storm pouring, I cough a little and am as hoarse as a frog. [October 4:] The recent weather, cold for the season, has been useful to me."

Another year, September 27:

"My catarrh is going off, or else it is having a long intermission; and for which ever it may be I am truly

thankful. [September 29:] Marshfield: My catarrh is greatly relieved. If I get through the night without a paroxysm I mean to set the lark an example of early rising tomorrow and listen to 'the murmurs of the Atlantic surge' before the sun fairly purples the east."

In 1839, Mr. Webster visited England and Scotland and since he was to be away during the early autumn and the period of the annual catarrh, Dr. James Jeffries, his physician, strongly advised against his going, but the provocation for the journey was sufficient to make him go, and it was the only year from the beginning of his disease until his death, that he was free from symptoms, and various ingenious explanations were given.

The attack of 1850 was especially severe and prolonged. On November 5 he wrote from Boston to President Fillmore:

"I left New Hampshire yesterday, having become free of disease and well, except so far as this protracted catarrh has reduced me. I am quite aware how inconvenient my long absence is to you, and to the government, and sometimes feel that as this illness is of annual recurrence I ought to regard it as unfitting me for office, the duties of which require constant attention."

The President's reply to this letter is not recorded, but there is reason to believe that during the ensuing winter the subject was discussed by the President and his Secretary of State, and I think it may be safely concluded that Mr. Fillmore urged Webster to continue in office, for on the next July 20, that is, in 1851, Mr. Webster wrote to Mr. Fillmore:

"But then, the great question, and the thing now most to be dreaded is the catarrh, which the next month has not failed to bring with it for so many years. In regard to this, I have adopted some new views and opinions arising out of a letter from the Reverend Mr. Croes, New Brunswick, New Jersey, a copy of which I enclose with this letter. I am persuaded that the voyages and journeys we discussed cannot be relied upon with any confidence, nor any change of air, nor the waters of any spring. I have laid Mr. Croes letter before Dr. Jackson of Philadelphia who has adopted its general ideas, and put me on a course of medicine, to be begun now, and rigidly adhered to until the the date of the regular attack of the disease shall come. He adds iodate of iron to the hydriodate of potash. I begin the course this day; and propose to remain here unless I should some time hence go as far as Maine or Vermont for general recreation, or unless I should be summone to Washington, which I hope will not happen for th present. I shall keep a clerk here and attend to every thing sent by Dr. Derrick, and especially everythin suggested by you."

Dr. Samuel Jackson of Philadelphia advised a that time:

"Your reliance must not be exclusively placed o the medicinal agents, the instruments for executin the plan of operation, and coming to aid a full effect you must assist yourself. I have to entreat you t avoid all exposures, fatigues, or whatever will dis tress or debilitate your economy. Such an occur rence will almost ensure defeat."

It was in that fall of 1851 when Mr. Webster ha seriously undertaken the treatment of his affliction that he almost came upon the great truth that Dr Wyman was to pronounce twenty years later. Th sequence of letters during the hay-fever season o 1851 is especially interesting.

[Boston, August 6 to President Fillmore:] "Fo myself I comply strictly with the regime of Dr Croes. Thus far, I get on pretty well, I do not think of going to Newport, because the climate of New port is exactly that of Marshfield, while Newport i filled up by crowds of people, whereas Marshfiel is quite excluded. Tomorrow I think of going t New Hampshire, hardly so much for a change of ai as to look after some private affairs. In general I find that those affected by my complaint avoid the interior and come to the coast. [Franklin, New Hampshire, August 10 to President Fillmore:] I came to this region on the morning of Thursday the 7th, thinking that the mountain air might strengthen me against the time when I expect my enemy, the catarrh, to attack me; and here I am, obeying Mr. Croes in all things, and getting a pretty good share of air and exercise. [August 12:] Sarah says she has not seen me look so well at any time as this morning, 'your eyes are like two bright buttons.' I begin to have hope, but shall not depart from my course of preventions for days to come. The enemy may come as a thief in the night, or he may be as bold as a lion. [August 19 to President Fillmore:] I have never had confidence that I should be able to avert entirely the attack of catarrh, but I believe that at least I shall gain so much in general health and strength as to enable me, in some measure, to resist its influence and mitigate its evils. Four days hence is the time for its customary approach. [August 23, 1851, to Mr. Blatchford:] Thursday morning 5:00 o'clock—A

tle foggy but will be a fine day. I cannot say that this moment I feel any symptoms of catarrh whatver, still I am cautious, and continue the use of all edicines, keep in doors except in fine weather, and oid everything which might give the enemy an pening through which he might enter. [August 25 Mr. Blatchford:] Sarah thought she saw catarrh my countenance yesterday. Today she sees none. s yet I do not sneeze, nor are my eyes affected. It as not stayed away so long before, yet it may come. August 26 to Mr. Blatchford:] There is no positive mptom or appearance of catarrh. In driving out esterday afternoon the wind freshened up and I neezed twice, but John Taylor sneezed three times. arah says my eyes are not quite so clear this morng as yesterday morning. But I think I can account r that. My system is so full of iron, potash and senic, that my stomach has become deranged. I ook a blue pill last night and a Rochelle powder is morning. The weather is clear and quite cool. Franklin, August 27, to Mr. Haven:] Thus far the atarrh holds off. It was due the 23rd, but as yet oes not show itself, but I dare not have confidence r some days yet that it will not come on in force. ur housekeeper, who has been with us ten years, nd is now here, never had any hopes that the annual ttack might be averted this time, until this morning. he now thinks that, by great care, it may be made pass by, I shall, I think, remain here some time nger. [August 31, to Mr. Blatchford:] Friday bout noon: I thought I felt catarrhal symptoms. here were some tendency of defluxion from the ose, the eyes did not feel right, and what was more nportant, I felt a degree of general depression hich belongs to the disease. . . . Next morng, 7:00 o'clock. I am glad I did not fill up this sheet st evening, as I am better today and have no bad igns or symptoms about me. [To President Fillore, September 8:] I have rather a hard time. I ave been able to keep off the catarrh so far, but it as called on me to take so much medicine as a good eal to derange my system. . . . I go to Boston oday where Mrs. Webster is, and thence immediately to Marshfield. By the process thus far, I have ost flesh, and am not a little reduced. Yesterday and unday were exceedingly hot, bright days, and lthough I did not step out of the house, the heat ffected my eyes much after the catarrhal fashion. resisted the attack, however, by the application of ce. . . . I think you will do very well to make Mr. Crittenden acting Secretary on his return. I hall make every effort to get to Washington before the month is out . . . all depends however, on the progress I make in regard to health. [Marshfield, September 15 to Mr. Blatchford:] Monday afternoon the weather appeared to cool a little and the cars not passing until six o'clock, I ventured on board for Boston. We were unlucky. The engine was thrown off the track by running over cattle, it was midnight before we got in. I took a heavy cold and the next day was quite ill all day. Wednesday afternoon I broke away by violence, and came hither by way of the Hingham boat. While in Boston, Doctor Jeffries advised me to leave off of medicine for a time. These things, or some of them, have caused a very sudden improvement. [Marshfield, September 28 to Mr. Fillmore:] Some times the force of the catarrh seems pretty much broken, and then it returns attacking the head, eyes, nose, etc. with great violence. I think it is approaching its last stage, which is the asthmatic stage. Some of our friends who are subjects of the complaint, and who have short necks, dread this. I do not fear much from this, although in this stage I feel its influence more or less on the chest. Given time, between the catarrh and the Harrisburg diarrhoea I am a good deal reduced. [Marshfield, October 4, to Mr. Fillmore:] The recent weather, very cool for the season, has been useful to me. The catarrh with its sneezing and nose blowing, its cough and its asthma seems to be taking leave; my eyes are still weak, but my greatest difficulty, at present, is a general want of strength."

A critical examination of Mr. Webster's 1851 experience is fruitful. Franklin, New Hampshire, is not quite far enough north to be in the ragweed-free belt, which does not extend much below the Profile, but the season of pollination in central New Hampshire is from ten days to two weeks later than it is in Massachusetts, and it seems reasonable to credit the delay in the onset of Mr. Webster's symptoms in 1851 to the later pollination rather than to Mr. Croes' polypharmacy. It may well have been that if Webster had stayed in the vicinity of Franklin through the season his symptoms would have been milder, for although ragweed is found in that locality, it is not as prevalent as it is on Cape Cod. All of the attempts to relieve his suffering from the disease were ill advised. It was his custom year after year, before the onset of symptoms to leave the city of Washington where the ragweed incidence is not especially high, and go to Marshfield, where, unless the flora changed between those years and now, his residence was surrounded by a lush growth of the offending plant. His principal mode of treatment

during the trying weeks was the ingestion of large amounts of whiskey, which has a somewhat contradictory effect upon hay-fever, increasing the severity of the symptoms by the stimulation of the peripheral circulation, but up to a certain point making those symptoms more bearable because of the exhilarating and anesthetic effects of alcohol. If one could stay at just the proper degree of inebriety during the hay-fever season, and did not have anything else to do, probably the disease would not be very troublesome, and there is some evidence which leads one to the conclusion that this is what Mr. Webster tried to do, with frequent errors on the plus side.

The year of 1852 seemed to bring renewed vigor to Webster and there is a certain blitheness in his letters that was lacking from his correspondence in the years just preceding. There are a number of factors which probably were of influence. He was strongly opposed to the Mexican war, and his son Edward died at San Angel. As time passed after that war was over, he seems to have been relieved of some definite anxiety. His personal finances appeared to be in sounder condition during this year, and his ever-present interest in husbandry seems to occupy an increased amount of time. As evidence of this changing spirit two letters are of interest. On March 13 he wrote from Washington to John Taylor, who was, in a sense, the manager of the estate at Marshfield, a letter in which he cautions Taylor to remember the old advice "to plow naked and sow naked," and then he goes on to explain,—perhaps thinking that Taylor might take the advice literally—that by this he means there is no use in beginning spring's work until the weather is warm, so that a farmer may throw off his winter clothes and roll up his sleeves. He then goes on to write three fairly lengthy quotations from Virgil, and closes the letter with "John Taylor, by the time you have got through this, you will have read enough. The sum of all this is, be ready for your spring's work as soon as the weather becomes warm enough, and then put in the plow and look not back."

On July 31 he wrote from Marshfield to Mr. Haven:

"I need a small boat in which my man could take me out in to the creeks and bays, when I have no company to go with me. A suitable boat would be one of 20 or 21 feet with a keel and a corresponding breadth of beam so as to make handsome proportions. I do not wish for tall masts, or anything else necessary to give extra speed. I want only a firm and safe boat, with suitable accommodations for fishing, and with power to make reasonable progress through the water. It would be well if the cuddy or covered forecastle should come pretty well back so as to keep out the water, and make a dry place to put things in in case of rain. I should like a rather large foresail, because with that I might generally run about from place to place without raising the mainsail. I should like to have her painted green and named 'The Julia of Green Harbor' [after his daughter Julia Webster Appleton who died in 1848]. Having given these general directions etc., all the rest must be left to the skill and taste of the builder."

Alas! the "Julia" was never built. From Washington on August 23 he wrote:

"This is my day, but I am quite well, and as yet feel no symptoms of approaching catarrh. The weather is very wet and I keep close at home, and I have my room constantly aired by fire. [On the next day, August 24, he wrote:] No catarrh yet, and the weather a little better."

Some time shortly after he went to Marshfield, and on September 12 wrote to Mr. Fillmore:

"The catarrh is upon me in all its various forms, alternating as usual, but as yet not so severe and heavy as on former occasions. My general health is not so much prostrated. If the weather be wet or damp, I must stay in the house, and have a little fire, to prevent fits of sneezing and nose blowing. When the sun is very bright I am obliged to avoid going out, on account of my eyes, except indeed when the sea is calm, and I am protected by an awning. The bracing air of the ocean, I find very beneficial. [On September 16 to Mr. Fillmore:] The catarrh is upon me in all its shapes, but by no means as oppressively as heretofore. The greatest difficulty, and the greatest danger is from my other complaint, and that is a constant tendency to diarrhoea. I have not eaten an ounce of flesh, fruit or vegetable since I arrived, nor do I use tea or coffee at all. My diet is milk with one half lime water, water gruel, and sometimes a little thin soup. [On September 30 to Mr. Fillmore:] Dr. Jeffries has been down and stayed two nights, and has frequently conversed with Dr. Porter, our local physician. [October 4 to Mr. Fillmore:] The doctors have agreed to have another conference before they made any statement. The reason is, that, all who know Dr. Jeffries and Dr. Porter, have entire confidence in them, yet friends in Boston insist that they shall be permitted

to send down a medical man of high reputation in his profession, and they have proposed either Dr. Warren Sr. or Dr. Jackson. [On October 8, to Mr. Fillmore:] Private and confidential—It is a great while since I have been hungry. The case is complicated by my catarrh."

Mr. Webster died on October 24, 1852.

According to Dr. Jeffries the cause of death was cirrhosis of the liver, there was also hemorrhage from the stomach and bowels, and extensive dropsy of the abdomen. The post-mortem examination disclosed that the brain was of the very largest known capacity, exceeding by 30 per cent the average weight; there was a well-marked effusion upon the arachnoid membrane, although there had been no perceptible evidence of any lesion during Mr. Webster's lifetime; and the foramen ovale of the heart was patent.

The interest of a medical historian in this subject is not limited solely to Mr. Webster's frank and whimsical record of his annual vicissitudes with the hay-fever. There is indicated an intelligent inquiry into the possible effect and influence that the disease may have had upon his career. Any attempt at an appraisal of this effect must be based solely upon the facts as we have them, and be free from romantic conjecture. The facts are these: With the exception of 1839, when he was in the British Isles, Mr. Webster for twenty years suffered from an annual attack of what was undoubtedly ragweed pollinosis. The severity of these attacks increased as time went on, and it is very evident that he had an increasing apprehension of the disease each year. It is certain that he wished to withdraw from Mr. Fillmore's cabinet in 1850 because of the handicap under which he was placed by the disease. There is some evidence that his chance for the candidacy for the presidency in 1852 was hindered by a realization that he was not in good health. So many other factors, including his alliance with Clay, his bid for favor from the South by his advocacy of the Compromise, enter into the consideration that the issue is by no means clear. Moreover, all of the facts have not been examined. There is material bearing on this period at Harvard, at Dartmouth College, and in at least one private collection, that must be explored before a fair conclusion can be reached.

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# EDITORIALS

## The Changing Order

When one inquires as to what is happening to medicine in this time of social upheaval, it is obvious that there is no adequate answer. It is certain that great changes are taking place and that these changes are bound to affect profoundly civilian medical practice. Even before the war the development of specialization, hospital usage and precision diagnosis had changed medical practice, particularly in urban areas, and the pattern of medical care had so developed that the economic aspects of even ordinary sickness represented in many instances a financial catastrophe. The turning to insurance plans against such disaster is a natural process, and it is now becoming clear that, unless such plans can be made to work through cooperative efforts of the public and the profession, it is inevitable that forms of so-called State medicine will have to come to the rescue. We already experience some limited forms of State medicine in our State hospitals, State sanatoria and certain free clinics. Furthermore, it should not be forgotten that Army medicine is essentially State medicine under military control. A recent writer has rather forcefully said, "If the Army can make State medicine work and solve this problem of free medical service, I think it is about time the medical profession get busy with a similar plan of their own making and under their own supervision, lest the politicians beat them to it."

Two developments seem inevitable in the near future: first, a development of medical practice toward group practice in close association with hospitals and laboratories; and secondly, a development along socio-economic lines in which the cost of sickness will be provided for by insurance methods either on the voluntary or on the compulsory basis. The necessity for the first change is being realized by the medical profession, for medical science of today demands the advantages to be gained by group endeavor, hospital facilities and readily available

laboratory aids. Its finest development will come when all of us appreciate some of the inadequacies of individual competitive practice and look for ways in which to adapt practice to the newer environments. The second development requires a considerable change in the traditional thinking of the average physician. Never having had training in the new concepts of social science, he may not take kindly to the idea that practice will require radical changes in order to make it available to all people. Furthermore, it must be recognized that these changes must be guided within the profession and that only through proper organization can effectual controls be established. It is not a moment too soon to seriously consider these things, for already there are those who are interested in having the government change the practice of medicine and who are interesting the farmers, the labor groups, and the agitators in their schemes. Medicine is not only being misrepresented by these self-appointed social planners, but it is saying too little about it. In Connecticut thus far we have been fortunate in this regard and our good fortune is due primarily to two things: first, medicine has for many years had the confidence of the people of our State and it has always taken an unselfish and an important part in the shaping and aiding of health measures for the public good; secondly, and this is especially true during the last few years, our State Medical Society organization, its officers and others responsible for the Society affairs have been on the alert to use all available means to foster and increase the public service for which the Society is dedicated. However fine and however efficient the unselfish work of these men is, it still must be augmented by the efforts of the individual practicing physician who should not only understand many of these present day problems, but who also should be able to discuss them intelligently. It must be plain from what has been said that the physician of today can no longer practice scientific medicine in isolation away from the many influences and benefits with which his Medical Society surrounds him. Evidence that this is generally recognized is seen in the fine support which has been given to the various Society enterprises, such as the JOURNAL, the Clinical Congress, the program in industrial health, to name but a few. Added to these are the Society's latest projects—the collection of funds for a permanent home and the beginning of a prepaid medical service plan. If these are to be successful it will require time, effort and straight thinking on the part of those who have been selected to guide them. These useful attributes have not been lacking thus far in the progressive course of our Society and, with confidence that every member will do his share, they will not fail us now.

## Hospital and Staff Problems

The development of the American hospital system had its beginnings in the Pennsylvania Hospital, built in 1752 under the guidance of Benjamin Franklin. It is true that before that time hospitals had been founded both in Mexico and Canada but the voluntary hospital system as we know it today had its roots chiefly in the Philadelphia establishment. The growth of hospitals in our own time has been remarkable and is common knowledge. In the United States during the last seventy-five years we have increased from 142 hospitals with 7,000 beds to something like 10,000 hospitals with 1,700,000 beds. That our hospital system portends something far beyond this is assured by the fact of the greatly increased interest of the public in Blue Cross and other forms of hospitalization insurance and more recently in medical care insurance.

Dr. George C. Adie, in considering some of these developments in a recent address given before the Hartford County Medical Association, has emphasized the role to be played by the hospital as a center of the medical life of the community, a unit around which medical service for the community can be built. In reviewing such changes F. J. Walker, past president of the American Hospital Association, points out that the success of future plans cannot be assured by the medical profession, or the hospitals, or the dental profession, or the nursing profession acting alone, but that cooperative thought and effort must be had if mistakes and misunderstandings are to be avoided. This thought impressed itself recently upon those in attendance at a meeting of the Council and the representatives of the Connecticut Hospital Association at which a frank discussion of the problems associated with radiological services demonstrated the need for and advantages to be gained from meetings of this kind. It is certain that most hospital and staff relationships are best served by such meetings. With an increasing tendency on the part of hospitals to employ physicians on a full time basis, it is obvious that the pattern of medical service in hospitals is changing. The discussion of such trends by hospital and professional groups should be a useful and productive enterprise.

The plan, as spoken of by Dr. Adie, to be carried

out at New Rochelle for a community health auditorium shows forward looking. The experience of the uses of the auditorium of the New Haven Medical Association for meetings on community health problems is ample evidence of the necessity for similar facilities in all urban areas. The hospital as a community health center is an ideal development for such a program.

Dr. Adie also speaks some wise words concerning the hospital as a center for medical education, particularly for intern training, and emphasizes the fallacy which is so apparent in the 9-9-9 program. Here again, in this field the value of representative cooperative effort is to be seen in the report of the sub-committee on intern curriculum of the State Post War Planning Board, published in the February issue of the JOURNAL. A review of the personnel of that committee shows a representation of medical, hospital, and medical society interests which was a potent factor in the development of this excellent plan for intern training. Taken in its entirety Dr. Adie's address is a timely contribution and it deserves careful and thoughtful reading.

## The American Legion Calls

Again the advice and assistance of the Connecticut State Medical Society has been sought out. This time it is the American Legion from whose State Commander, Herbert L. Emanuelson, has come a request for suggestions for the appointment of a Medical Advisor to the Legion in Connecticut and a committee to serve with this State Medical Advisor. The American Legion has established a Medical Advisory Division on the national level with Colonel Leonard G. Rowntree, formerly Chief Medical Officer of the National Selective Service System, as chairman of the Division.

This request from the State Commander of the American Legion should come as no surprise to the physicians of Connecticut. It is not the first lay organization that has turned to our Society in recent years for advice in selecting physicians to serve as consultants in fields of health and medical care. We welcome such opportunities. The request from the American Legion carries with it particular significance at this time when legislation pertaining to the returning veteran of World War II is in the making and when an investigation of the present Veterans Administration is imminent. The memory of the chaotic legislation following World War I is all too fresh in our memories. Physicians serving with the Armed Forces in that former war joined the Legion in proportionately small numbers. Their advice in formulating legislation for the veteran was seldom sought and less frequently followed. Today we are confronted with a Veterans Administration to which has just been appropriated another $105,900,000 for the operation of its hospitals. Complaints of the inadequacy of these hospitals are coming in from all sides. They are said to be isolated from contact with modern and scientific universities, hospitals and clinics. They are said to resemble nursing homes for permanent patients rather than modern hospitals. More funds are believed spent for beautifying the grounds than for scientific equipment, medical independence is absent, practice is regimented, no freedom of independent judgment is permitted. No opportunity for research is said to be available and an estimated one-third of a physician's time is consumed in making out reports.

All this should be changed. The American Legion will be active in the initiation of veterans' legislation and in the care of the welfare of the veteran following this war just as it was after the last war. Physicians should view all such medical legislation with vital interest and whenever possible wield an influence in its formulation. To have this opportunity placed upon our doorstep is most fortunate and should impress us with the realization that our influence as an organized group is being counted upon.

## The Marihuana Problem

Elsewhere in this issue of the JOURNAL appears a review of the book entitled "Marihuana Problems," written by the New York City Mayor's Committee on Marihuana. That the authors of this book arrive at unwarranted conclusions is noted in the review by Dr. Knowlton. Even though there exists considerable confusion in the literature as to the harmful effects of cannabis sativa, yet sufficient evidence has already been collected to place this habit forming drug in the category of dangerous addiction. Most authors would classify it somewhere between alcohol and morphine in its addicting qualities because the end result of addiction depends to a larger extent on the personality involved rather than on any physiologically addicting properties of the drug.

This last point is emphasized by Captains Marcovitz and Myers, MC—AUS, in a recent article in *War Medicine*.[1] These writers believe that a com-

[1] "The Marihuana Addict in the Army"—*War Medicine*, Vol. 6, No. 6, Dec. 1944.

## The Personal Letter

The Trustees of the Building Fund, at their meeting in New Haven on May 10, expressed great satisfaction at the progress to date made by the Building Fund campaign. Many of our members have given generously. Every county has been well represented in the total amount pledged. But every member has not given something and this is the goal set by the Trustees before the campaign closes.

To this end a personal letter has gone out from the Trustees of the Building Fund to those who have not contributed thus far. No figures have been published, listing individual gifts. It is not the wish of the Trustees to embarrass any physician in Connecticut. It is their belief, however, that many have overlooked the pledge card previously sent, or have laid it aside, or are still waiting to make a decision on the amount.

The campaign is going well and the new home for the Society is assured. To make it the kind of a home it should be, you should have a part in it. No member in the service of the Armed Forces will be asked for a contribution. When they return we hope to be able to express to them our gratitude by presenting them as members of our Society with a new home.

Your part in this gift may be just as large or just as small as you see fit, only *give something!*

pletely adequate estimate of the effects of marihuana can be obtained only from considering the entire life pattern of the addict: i.e., the addict in relation to himself and to society. Over against the statements in the literature that marihuana is not harmful, that it is not an addicting drug, and that it has not led to crime, we have the findings of these Army physicians that the addicts show a lack of social ties and of warm relationships, that there are paranoid elements present and the feeling of superiority, that there is delinquency and antisocial behavior, depressive feelings and headaches, and self injury, as well as a definite addiction to the drug.

Dr. Fishbein in an editorial in the *Journal of the American Medical Association*[2] informs us that the book eminating from Mayor LaGuardia's conservatory has already done harm, among the legal profession as well as among the laity. To add fuel to the fire by proposing, as the report does, that marihuana may be used in the treatment of drug addiction and chronic alcoholism is like taking away a Colt .45 and substituting a machine gun. This could hardly be justified in view of the recommendation of Marcovitz and Myers that "government institutions be created to which such confirmed marihuana addicts may be committed for long term treatment and rehabilitation or for indefinite custody." It is to be hoped that in Connecticut, at least, the report of the Mayor's committee will be given the universal condemnation it warrants and that physicians will not overlook the permanent deleterious effects of marihuana.

[2] *J. A. M. A.*, Vol. 127, No. 17, April 28, 1945.

## Dangerous Legislation

All sorts of unwise legislation is stirred up in the ferment of war. It is a time of happy hunting for minorities who seek advantage through the real or fancied needs and shortages of war time.

One of the best and the worst examples of this sort was legislation introduced into the Assembly in the State of New York that would permit any graduate of any medical school, anywhere, to take the examinations leading to licensure to practice medicine. The bill had such strong support from so many people who were convinced that there was a shortage of physicians in New York State because of the war, or who were champions of the underdog, or who were seeking advantages for graduates of substandard medical schools, that it passed the New York Assembly and would have become law if it had not been vetoed by Governor Dewey.

In his veto memorandum the Governor wrote, "The Department of Education, which is charged with responsibility for medical educational standards, has approved a large number of schools and had declared that certain others are substandard. These bills would overrule the chosen agent of the people of the State, the Department of Education, and make admissible to practice medicine, men whom the department declares may not be trusted with the great privilege and responsibility.

"The lives and health of the people of the State are a sacred charge. They cannot and must not be exposed to the danger of bad medical treatment. The Department of Education certifies that such would be the result of these bills and I am compelled, therefore, to disapprove them."

## Cancer Organization and Propaganda

Under this title Dr. Charles L. Larkin points out some fallacies in the program for lay cancer education and emphasizes the importance of cancer consciousness on the part of the physician. The author's work in the field of cancer control in Connecticut is well known, as is his pioneer work in the organization of the Connecticut Tumor Committee. Dr. Larkin's consideration of state cancer hospitals is interesting and constructive and his remarks about the education of physicians timely and important. "This is the hour in the cancer fight," says a recent writer, "which calls for a solemn self-analysis by every practicing physician that he may play his role creditably and in full accord with the tradition of his profession and the confidence and trust of his patients."

## The Summer Catarrh

In *One Man's Meat*, already an American classic, E. B. White writes under the above title of Daniel Webster's and his own experiences with hay fever. We surmise that not a little of the material which found its way into this fine chapter of the author's inimitable humor, had its source in an essay entitled "Daniel Webster and the Hay Fever" by Creighton Barker. Mr. White informs us in an early paragraph that he has "just come across it in my files and have reread it with the closest attention." Dr. Barker's paper was read before the Beaumont Medical Club in 1937 and is reprinted in this issue for the benefit of those of our readers who have not had access to the original publication.

## Cancer Drive Goes Over

The members of The Connecticut State Medical Society offer congratulations to The Connecticut Cancer Society on the success of the recent campaign to raise funds which will aid in fighting cancer. The collection from the citizens of our state is already well over $100,000, which shows the great public interest in this problem and brings to the profession opportunities and responsibilities which must be faced with serious consideration. As Dr. Creadick has pointed out in his presentation, it is the physicians who must lead the way and it is they who must direct the public thought along paths which represent the truth concerning cancer and its cure. Furthermore, it must be obvious that whatever is done must and will be a cooperative enterprise between them and The Connecticut Cancer Society. To Dr. Creadick and his associates has come a unique opportunity and we shall look forward with interest to the plans of The Connecticut Cancer Society for furthering the attack on the cancer problem.

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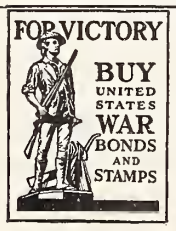
## A. M. A. Bureau of Information In Action

Most important to medical organization is the proper reception of the returning veteran medical officer into civilian practice. Plans already are under way in many states and communities so that discharged medical officers may take up their work after the war under the best conditions possible.

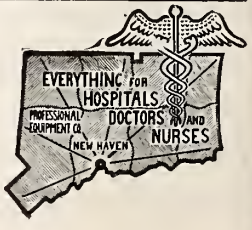
An important factor in this program is the work of the Bureau of Information of the American Medical Association created to serve the physician in the armed forces. In charge of this Bureau is Lt. Col. Robert D. Bickel who served for twenty-nine months in the China-Burma-India theater before his assignment to the American Medical Association headquarters by the Office of the Surgeon General.

The Bureau is collecting and tabulating information on local medical facilities and openings so that this data may be available and aid the returning doctor in making his decision as to where to locate.

To obtain latest information the Bureau has sent "summary sheets" covering all counties by states to each state society secretary.




YOURS FOR THE BASKING — Our complete rental service includes various types of sun lamps available to your patients on prescription. Everyone who needs the tonic benefits of ultra-violet these busy "all out" days, cannot spare the time to bask on the beach, but details on PROFESSIONAL summer sun for everyone, for convenient bedroom use, is yours for the asking. Professional Equipment Co., New Haven.




(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## SPECIAL MEETING OF THE COUNCIL

The Council held a special meeting in New Haven on April 20 in conference with the Board of Trustees of the Connecticut Hospital Association. There were present from the Society: Drs. Miller, Jarvis, Weld, Landry, Howard, Thoms, Russman, Murdock and Barker; from the Hospital Association: Messrs. Sweeney, Hancock, Hamilton, Pfirman, Brough and Miss Griffin. There were absent from the Society: Drs. Campbell, Gildersleeve, LaMoure, Mullins, Paine and Weed.

The purpose of the conference was to discuss the practice of radiology in hospitals in Connecticut and the relationship of radiologists to hospitals and it had been arranged in compliance with a request of the special committee from the Section on Radiology of the Society.

The chief objectives of the radiologists appeared to be a change in the system of hospital billing for radiological services in order that the charges for radiology might be separated into two parts, (a) the professional fee, and (b) the hospital fee. The radiologists had also proposed that the professional fee to be included in these separated charges be fixed by radiologists.

Long discussion of these proposals ensued during which it was pointed out that this separation of radiological charges did not have the approval of national organizations of radiologists or the American Hospital Association.

The Trustees of the Hospital Association were not prepared to make any definite commitment on the part of Connecticut hospitals because the proposals of the radiologists had not yet been submitted to the Hospital Association membership. This was to be done, however, at a meeting of the Association to be held on May 1, after which the Hospital Association agreed to communicate the results of its deliberations to the Society.

AFTER THIS CONFERENCE THE COUNCIL WENT INTO EXECUTIVE SESSION.

It was voted that Student Members of the Society be given the privilege of subscribing to the STATE MEDICAL JOURNAL at a special annual subscription rate of $2.

Organization procedure for the Connecticut Medical Service Plan was discussed at length and nominations made for eleven persons to serve as incorporators of the corporation to be organized. The Secretary was instructed to confer with Mr. Arnon Thomas, the Society's counsel, and at an early date to arrange an organization meeting to which these incorporators will be invited.

It was voted to present to the House of Delegates a recommendation extending the period of exemption from the payment of dues for members of the Society returning from military service.

## County Association Officers 1945 - 1946

FAIRFIELD COUNTY

President: George B. Garlick, Bridgeport
Vice-President: John D. Booth, Danbury
Secretary: J. Grady Booe, Bridgeport
Treasurer: Clifton C. Taylor, Bridgeport
Councilor: Samuel F. Mullins, Danbury

HARTFORD COUNTY

President: Edward A. Deming, Hartford
Vice-President: Aaron P. Pratt, East Windsor
Secretary-Treasurer: Samuel Donner, Hartford
Councilor: D. C. Y. Moore, South Manchester

LITCHFIELD COUNTY

President: Donald W. Herman, Winsted
Vice-President: W. Bradford Walker, Cornwall
Secretary-Treasurer: Thomas J. Danaher, Torrington
Councilor: Floyd A. Weed, Torrington

MIDDLESEX COUNTY

President: Chester Waterman, Middletown
Vice-President: Charles Russman, Middletown
Secretary: Frank H. Couch, Cromwell
Councilor: Harold E. Speight, Middletown

NEW HAVEN COUNTY

President: Ralph W. Nichols, New Haven
Vice-President: M. Heminway Merriman, Waterbury
Secretary-Treasurer: Ralph E. McDonnell, New Haven
Councilor: Herbert Thoms, New Haven

NEW LONDON COUNTY

President: John F. O'Brien, Waterford
Vice-President: Harold W. Higgins, Norwich
Secretary-Treasurer: Thomas Soltz, New London
Councilor: George H. Gildersleeve, Norwich

TOLLAND COUNTY

President: Leonard W. Levine, Ellington
Vice-President: Charles T. LaMoure, Windham Center
Secretary-Treasurer: Francis H. Burke, MC—AUS
Acting Secretary: John E. Flaherty, Rockville
Councilor: Charles T. LaMoure, Windham Center

WINDHAM COUNTY

President: Andrew O. Laakso, Danielson
Vice-President: Nathan Spector, Willimantic
Secretary-Treasurer: Brae Rafferty, Willimantic
Councilor: Robert C. Paine, Thompson

## New Members Elected April 1945

FAIRFIELD COUNTY

Gaza Edward Buda, Univ. of Zurich 1937, Stratford
Francis Michael Burns, Columbia P & S 1939, Shelton
Arthur Paul Capobianco, New York Medical College 1940, Bridgeport
Joseph G. Fisher, Univ. of Paris 1911, Greenwich
Jacob Greenblatt, Univ. of Louisiana 1939, Stamford
Robert Battaile Hiden, Univ. of Virginia 1923, New Canaan
Frederic Lewis, Long Island College of Medicine 1936, Stamford
David Olan Meeker, Univ. of Rochester 1929, Cos Cob

HARTFORD COUNTY

Jerome Murray Hopper, Univ. of Chicago 1940, Hartford
Frank Zwick, Univ. of Vermont 1913, New Britain

NEW HAVEN COUNTY

John Brody, Tufts 1939, New Haven
Marion Snyder Brown, Temple 1944, Meriden
Joseph Harold Evans, Boston University 1902, New Haven
William John Lenkowski, New York University 1937, Waterbury
Frank James Lepreau, Jr., Harvard 1938, New Haven
William Joseph McNamara, Vermont 1929, New Haven
Kenneth Remsen Morgan, Yale 1942, New Haven
Hoyt Chase Taylor, Cornell 1938, MC—USNR
Maurice Tulin, Yale 1942, New Haven
Herbert Theodore Wagner, Jr., Univ. of Indiana 1937, Meriden
Johanna Waldemar-Kertesz, Univ. of Vienna 1926, New Haven

NEW LONDON COUNTY

Kathryn May Bryan, Hering 1904, Norwich
Riley Henry Guthrie, Univ. of Tennessee 1921, Norwich

## Student Members

FAIRFIELD COUNTY

| | |
|---|---|
| Barnes, George R., Jr., Yale | Bridgeport |
| Baum, Seymour J., U. Vermont | Bridgeport |
| Colmore, John P., P. and S. | Darien |
| Davis, David K., Georgetown | Stamford |
| DeLuca, Joseph V., Georgetown | Bridgeport |
| Gordon, Robert S. P. and S. | Bridgeport |
| Heins, Jacob W., Cornell | Darien |
| Heller, John H., West. Reserve | Wilton |
| Jeck, Howard S., Jr., Cornell | Westport |
| Levy, Lewis L., Temple | Stamford |
| Liebler, John B., Temple | Greenwich |
| Long, Edwin T., P. and S. | Redding |
| Lutz, Louise, Long Island | Westport |
| Mandell, Marshall, Long Island | Norwalk |
| Mathews, Hugh T. J., Hahnemann | Stamford |
| McElfresh, Arthur E., Cornell | Greenwich |
| Molnar, Charles J., Jr., Georgetown | Bridgeport |
| Noonan, Robert H., Long Island | Bridgeport |
| O'Looney, John J., Jr., Jefferson | Bridgeport |
| Plucinski, Theodore E., Long Island | Bridgeport |
| Pope, Russell H., Johns Hopkins | Stratford |
| Sachs, Julian A., Yale | Danbury |
| Samuelson, Arthur W., Tufts | Bridgeport |
| Savin, Sanford, U. Vermont | Bridgeport |
| Scialla, Michael M., West. Reserve | Bridgeport |
| Small, Alan R., N. Y. Med. | Bridgeport |
| Sokolski, Edward J., U. Maryland | Bridgeport |
| Steel, Robert M., Boston U. | Stratford |
| Szabados, Ernest D., Marquette | Fairfield |
| Tella, Ralph T., Tufts | Stamford |
| Tierney, James W., U. Vermont | Norwalk |

| | |
|---|---|
| Wasserman, Edward, Yale | Bridgeport |
| West, William L., U. Vermont | Shelton |

ARTFORD COUNTY

| | |
|---|---|
| Atwood, Albert S., Yale | East Hartford |
| Bailo, Jsoeph J., Marquette | Windsor Locks |
| Ballien, Theodore C., Hahnemann | West Hartford |
| Bamforth, Betty J., Boston U. | New Britain |
| Bayer, Alexander E., U. Vermont | New Britain |
| Bellizzi, Joseph J., Tufts | Hartford |
| Benson, John A., Jr., Harvard | Windsor |
| Bohman, Frank E., Jr., Hahnemann | West Hartford |
| Bray, George H., U. Vermont | New Britain |
| Bridge, Allyn G., Yale | Hazardville |
| Bucknam, Frank G., Harvard | Farmington |
| Bundy, Edward S., U. Vermont | Southington |
| Burton, Richard W., Boston U. | East Hartford |
| Callahan, James L., Georgetown | New Britain |
| Carey, John M., Harvard | Newington |
| Carrabba, Salvatore R., Jefferson | Hartford |
| Castagno, A. Joseph, Long Island | Hartford |
| Catlin, Francis I., Johns Hopkins | West Hartford |
| Chace, Charles W., Long Island | Newington |
| Cote, Richard H., Yale | East Hartford |
| Cullina, Joseph C., Geo. Washington | Hartford |
| Curran, Sidney J., Albany | New Britain |
| Danyliw, Joseph M., Jefferson | Hartford |
| Donohue, Stephen M., Tufts | Wilson |
| Dossin, Robert H., Hahnemann | Newington |
| du Prey, Robert E., Jefferson | Hartford |
| Dyer, Richard R., Yale | Berlin |
| Fichtner, Paul A., Long Island | Simsbury |
| Gerent, Walter P., Hahnemann | New Britain |
| Grody, Marvin H., U. Penn. | Hartford |
| Goldenburg, Philip T., Boston U. | Hartford |
| Griffin, Robert J., Boston U. | Hartford |
| Gustafson, Walter E., Yale | Manchester |
| Hagedorn, Maxwell E., Jefferson | East Hartford |
| Johnson, William E., Harvard | Hartford |
| Kerin, Robert J., Yale | New Britain |
| Kondonellis, Venizelos E., N. Y. Med. | New Britain |
| Knickerbocker, Charles H., U. Penn. | Windsor |
| Konefal, Stanley H., Boston U. | East Berlin |
| Kosar, Walter P., P. and S. | Hartford |
| Mandell, Julian, Boston U. | Hartford |
| Mann, Norman M., Long Island | Hartford |
| Marzialo, Nicholas A. H., Tufts | Hartford |
| Mittelman, Jay A., U. Penn. | West Hartford |
| Molloy, Robert J., Cornell | West Hartford |
| Myers, Lonny, U. Michigan | West Hartford |
| Opinsky, Morton, Georgetown | Hartford |
| Peterson, Richard C., Yale | Wethersfield |
| Pizzo, Paul S., N. Y. Med. | Hartford |
| Rowley, Samuel D., Jefferson | West Hartford |
| Rucci, Alfred J., Tufts | Hartford |
| Russo, Nicholas J., U. Vermont | Hartford |
| St. John, Nicholas E., Geo. Washington | Hartford |
| Silver, David, Boston U. | West Hartford |
| Vicas, Benedict, Georgetown | Hartford |
| Wadlund, Robert R., U. Vermont | Wethersfield |
| Williams, William E., P. and S. | Farmington |
| Wood, John M., U. Vermont | Hartford |

LITCHFIELD COUNTY

| | |
|---|---|
| Alban, Emil J., Geo. Washington | Torrington |
| Foord, Edward, Yale | Litchfield |
| Lyons, Robert T., Geo. Washington | Falls Village |
| Watson, Alan D., Harvard | Kent |
| Weld, Paul W., Yale | Watertown |

MIDDLESEX COUNTY

| | |
|---|---|
| Harvey, Sanford W., Cornell | Middletown |
| Milburn, John D., Hahnemann | East Hampton |
| Ziagra, Sumner R., Yale | Deep River |

NEW HAVEN COUNTY

| | |
|---|---|
| Albis, Francis J., Marquette | New Haven |
| Anderson, Betty-Jane M., Tufts | Guilford |
| Audet, Charles H., Jr., U. Maryland | Waterbury |
| Behrle, Franklin C., Yale | Ansonia |
| Blansfield, Henry N., Yale | Waterbury |
| Cappelletti, A. Joseph, Jefferson | Waterbury |
| Chernoff, Amoz I., Yale | New Haven |
| Collins, William F., Jr., Yale | New Haven |
| Cusanelli, Gabriel N., Long Island | New Haven |
| Dickinson, George H., Jr., U. Vermont | Meriden |
| Doherty, Robert C., U. Vermont | Meriden |
| Doolan, Paul D., Georgetown | Hamden |
| Drill, Victor A., Yale | New Haven |
| Flynn, John H., Yale | Hamden |
| Frechette, Eugene J., Jr., N. Y. Med. | New Haven |
| Gagliardi, Raymond A., Yale | New Haven |
| Gelb, Lester A., Long Island | East Haven |
| Golia. Ulysses V., Long Island | New Haven |
| Golkowski, William V., Jr., Albany | West Haven |
| Huber, H. Crane, Jr., Temple | Waterbury |
| Jenusaitis, John R., Tufts | Waterbury |
| Kalbacher, Joseph E., Cornell | Hamden |
| Kazanjian, Norton A., Hahnemann | Naugatuck |
| Kennedy, John J., Jr., Boston Univ. | New Haven |
| Kreis, David J., Tufts | Hamden |
| Kreske, Frank V., N. Y. Med. | West Haven |
| Kristan, Joseph J., Johns Hopkins | Wallingford |
| Laudano, Andrew J., Tufts | New Haven |
| Leavenworth, William M., West. Reserve | New Haven |
| Lethin, Anton N., Yale | New Haven |
| May, Samuel C., Yale | Hamden |
| McLean, Charles E., Yale | Wallingford |
| McDonnell, Robert R., Jefferson | New Haven |
| Mendillo, John J., P. and S. | Hamden |
| Mereschak. Volmar A., U. Penn. | Ansonia |
| Murdock, Charles L., N. Y. Med. | Clinton |
| Nowlis, Gerald R., Yale | New Haven |
| O'Connell, Thomas J., N. Y. Med. | West Haven |
| O'Neill, John J., Tufts | New Haven |
| Peters, Richard M., Yale | New Haven |
| Reilly, Walter M., Hahnemann | Naugatuck |
| Riege, David H., Yale | New Haven |
| Rosoff, Chester B., Harvard | Hamden |
| Santopietro, Olindo. N. Y. Med. | Waterbury |
| Schwartz, Robert, Yale | Hamden |
| Tator, Robert B., P. and S. | New Haven |
| Williams, Marshall H., Jr., Yale | New Haven |

NEW LONDON COUNTY

| | |
|---|---|
| Carpenter, John C., Yale | New London |
| Dyer, Charles F., Cornell | New London |
| Enos, William F., Jr., Long Island | Norwich |
| Falcone, Ralph A., Tufts | Norwich |
| Flanagan, George M., U. Penn. | Niantic |
| Irwin, Charles, U. Vermont | New London |
| Murray, William J., Jr., Cornell | New London |
| Nolan, Robert K., U. Vermont | Norwich |
| Paskiewich, Nicholas, Albany | Norwich |
| Sherwin, Russell P., Dartmouth | New London |

TOLLAND COUNTY

| | |
|---|---|
| Johnson, Carl W., Boston U. | Andover |
| Moriarty, Thomas F., Jr., Georgetown | Stafford |
| Perry, Lawrence C., Yale | Andover |
| Sokoloski, Chester A., U. Michigan | Rockville |
| Virshup, Bernard B., Long Island | Somers |
| Virshup, Milton, Long Island | Somers |

WINDHAM COUNTY

| | |
|---|---|
| Bell, Robert W., Boston U. | Danielson |
| Tourtellotte, Charles R., Dartmouth | North Grosvenordale |

## Eye Bank Established in New York City

Formation has been announced of The Eye Bank for Sight Restoration, Inc., which will collect and preserve healthy corneal tissue from human eyes for transplanting to blind persons who have lost their sight because of corneal defects. The organization, national in scope, has been incorporated under the laws of New York State and 22 leading hospitals in New York City are now affiliated with it; in addition, 20 outstanding ophthalmologists throughout the country will serve in an advisory capacity. Headquarters are at 210 East 64th Street, New York City.

Between 10,000 and 15,000 blind persons with corneal defects, in the United States, may have an opportunity to see again through the activities of The Eye Bank. The operation substituting a healthy cornea for a damaged one can restore sight in only one type of blindness, that caused solely by opacity of the cornea when the rest of the eye and optic nerve are normal.

The Eye Bank has been established in order to make available to hospitals and surgeons who are qualified to perform the corneal graft operation a supply of fresh or preserved corneal tissue, wherever and whenever needed. In brief, the objectives are:

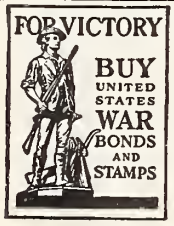
To encourage and extend, by teaching and research, the knowledge and skill required to perform the operation. No money has been raised as yet for the Eye Bank, but fellowships will be established when sufficient funds have been raised. Eye institutions throughout the country may apply for these fellowships.

To establish sources of supply of salvaged eyes and corneal tissue; to establish an eye bank for the collection, preparation, storage and redistribution of salvaged eyes and corneal tissue; to discover, by intensive research, a method for preservation of the corneal tissue over a longer period than is now possible.

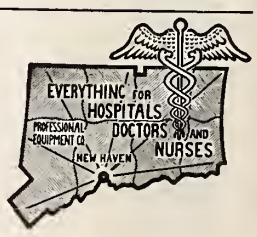
Any eye which is sent to the Eye Bank and not used will have a complete pathological study made and a report sent to the institution which supplied the eye; also bacteriological studies will be made for possible contamination, etc. Of course any institution desiring to make their own pathological examination will have the eye returned to them in the proper preservative fluid. There are naturally many smaller institutions that do not have the facilities for the proper pathological examination of eyes, and one of the purposes of the Eye Bank is to encourage complete pathological studies of all eye tissues sent to them.

Initially, the needed space and personnel has been made available in the Manhattan Eye, Ear & Throat Hospital. The Eye Bank will acquire additional space, personnel and equipment as needed, so as to serve not only the New York area but localities throughout the country.

It is also hoped to establish scholarships and fellowships for instruction in surgery, pathology and related essential techniques for sight restoration by operations on the cornea.




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

## President-Elect Attends Detroit Meeting

*The following letter, written to the Members of the Council by the President-Elect, Dr. Joseph H. Howard, contains matters of interest for every member of the Society.*

May 2, 1945

Gentlemen:

On the invitation of Dr. Brunk, President of the Michigan State Medical Society, the presidents of seventeen State Medical Societies met in Detroit on April 27 and 28 to discuss matters pertaining to public relations. Since Dr. Jarvis was unable to attend, I represented the Connecticut State Medical Society. Presidents of the following states were present: Connecticut, Delaware, District of Columbia, Kentucky, Illinois, Indiana, Iowa, Massachusetts, Minnesota, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island and Wisconsin. The program was as follows:

On Friday, April 27, luncheon was held at the Detroit Athletic Club with the members of the Executive Committee of the Council of the Michigan State Medical Society. At this session, two members of the American Medical Association were present, and agreed with the various speakers that the American Medical Association has not come forward with any definite plan to combat legislation before Congress and before the various State legislatures. Everyone at the meeting agreed that some very definite plan should be put into effect to stimulate the American Medical Association to more definite action. Several groups throughout the country are working independently, but there is no unified program.

After this meeting a tour of the Michigan Medical Service headquarters was conducted by the managing director, and the details of the working of the organization were described. Apparently they have overcome a great many difficulties after a bad start and are now well on the road to success. Any details regarding this service will be explained at the next Council meeting.

In the evening a dinner was served at the home of the Wayne County Medical Society. The guest speaker that evening was Mr. Kettering of the General Motors Company who spoke of the advisability of a closer working relationship between the medical profession and the various other sciences. Mr. Kettering was not critical but did feel that the medical profession was rather lax in not presenting more definite plans on the improvement of medical care. At this meeting the radio program as sponsored by the Michigan Medical Society was described, and because of the success of this program, it was felt that the seventeen states should unite in offering a similar program for a period of at least thirteen weeks. The area covered would include approximately seventy-one million people, and in this area there are seventy-five thousand physicians. The plan was to select the most powerful stations in this particular area and to broadcast between seven-fifteen and seven-thirty o'clock one evening each week. A sample broadcast was given for us during the dinner. It was quite dignified, and I doubt whether anyone would consider that there was any commercial taint to it.

A committee was appointed to bring this matter before the Councils of the various medical societies to discuss the advisability of this radio feature. The cost for the thirteen weeks would be approximately eighty-four cents per member for the entire series.

The second matter discussed was that of preparing some concrete plan to be submitted to the American Medical Association for presentation to Congress to combat the present legislation. A Committee was therefore appointed to urge each state to present such a plan, after which these various suggestions would be crystallized into one uniform plan.

On the morning of April 28 the group was conducted through the Willow Run Plant of the Ford Motors Company, and at noon had luncheon as guests of the Ford Company in the rotunda. Dr. McClure, chief surgeon of the Ford Hospital, welcomed the group, and in his remarks mentioned the fact that a prominent member of Congress had made a tour of the Willow Run Plant a short time before. Dr. McClure discussed with this Congressman the legislation before Congress on medical practice, and the latter assured Dr. McClure that he was not in favor of the present Murray-Dingell Bill, but since the medical profession had not come forward with any substitute, he felt that some legislation had to be put through, and since no other was advanced, the present bill or a modified bill of this type might be adopted.

Anyone attending this meeting would be quite impressed with the enthusiasm of this Michigan group. They are, unquestionably, leaders in this field as shown by the initiation of the largest and most successful medical service in the country and newer plans for vigorous and progressive action in

matters of public relations.

I should be very happy to answer any questions and to discuss these details further at the next meeting of the Council. I hope that you will give these matters considerable thought since definite action should be taken without delay.

Respectfully submitted,

Joseph H. Howard, M.D., President-Elect
Connecticut State Medical Society

## Report of the Connecticut State Fracture Committee, American College of Surgeons

Under the chairmanship of Robert M. Yergason the Connecticut State Fracture Committee of the American College of Surgeons held its quarterly meeting at St. Francis Hospital where an interesting program on the care of fractures and other traumata was presented to thirty members and guests from various parts of the state.

Maurice F. O'Connell discussed tri-malleolar fractures and their treatment.

John F. McDermott presented a case in which the fragments of a comminuted fractured patella were removed with a very satisfactory result. There was considerable discussion of this procedure which developed many interesting additional opinions.

Thomas F. Luby showed x-ray studies of non union of the neck of the femur in which a subtrochanteric osteotomy was performed to bring about union.

R. M. Yergason, the chairman, presented removable fixation devices to be used in fracture treatment. As usual Dr. Yergason's ingenuity and accomplishments were demonstrated with several original ideas and apparatus shown for the benefit of those present.

C. W. Goff showed a motion picture in color on knee joint surgery with special reference to the removal of the medical meniscus. He also discussed Dr. Luby's paper and presented several problem cases in which the Moore and Blount Blade Plate was used for fixation following both a high and a low osteotomy of the femur.

A buffet luncheon was served by the superintendent of St. Francis Hospital in the Nurses' Library between the morning and afternoon sessions.

These quarterly meetings have been well attended and prove that there is a stimulating interest in fracture treatment persisting during these difficult wa times.

The next meeting is expected to be held in Nev Haven under the auspices of Drs. Henze, Rober Cook and Eveleth.

Further notices will be forthcoming in the Jour NAL and individual members and their friends wil be notified of such arrangements.

C. W. Goff, M.D., Secretary-Treasurer

## Dinner to Honor Dr. Robert E. Peck

Dr. Robert E. Peck, who retires this year a Director of the Department of Physiotherapy a Grace Hospital, was the honored guest at a dinne given at the New Haven Medical Association Apri 28, 1945. Dr. Peck, who has been associated wit Grace Hospital since 1919, expects to make hi future home in Dunbarton, New Hampshire. Thos present at the dinner were Mr. Robert S. Judd president of the Board of Directors, Grace Hospital Mr. Sidney G. Davidson, superintendent, Grac Hospital, and Drs. C. J. Bartlett, F. G. Beck, H. A Conte, R. J. Cook, C. L. Deming, W. C. Duffy. C. J. Foote, H. J. Giamarino, S. J. Goldberg, B. Greenhouse, G. J. Jack, M. Lear, H. A. Levin, D. Levy, J. I. Linde, R. M. Lowman, D. R. Lyman. L. L. Maurer, W. Mendelsohn, A. J. Mendillo, L. K. Musselman, R. W. Nichols, H. B. Perrins, F. L. Phillips, D. Poverman, W. Powell, B. A. Rogowski, T. H. Russell, W. I. Russell, C. E. Sanford, M. M. Scarbrough, R. F. Scholl, S. J. Silverberg, M. R. Smirnow, C. S. Smith, F. B. Standish, M. Strauss, J. F. Sullivan, H. Thoms, L. H. Wheatley.

## Prepaid Medical Service Committee Meets With Connecticut Hospital Service, Inc.

On April 11 the Committee on Prepaid Medical Service of the Connecticut State Medical Society held a joint meeting with the Committee on Medical Service Plans of the Connecticut Hospital Service, Inc., at the Quinnipiack Club in New Haven. At this joint meeting it became very clear that the proposed Prepaid Medical Service Plan is the responsibility of the State Medical Society. To implement organization, counsel has been selected and articles drawn up for the formation of a new corporation. On May 25 eleven individuals selected by the Council as corporators were invited to meet to complete the plans for organization.

# MEDICINE AND THE WAR

## CONNECTICUT HAS FINE FACILITIES FOR HOSPITALIZATION OF VETERANS

Carl A. Gray

The Author. *Chairman, Connecticut Reemployment Commission*

Connecticut may well be proud of the provisions which have been made and are being made for the hospitalization and domiciliary care of its war veterans.

There are several reasons why this is so. One is the fine modern veterans' hospital and home provided by the State at Rocky Hill. Another is the excellent hospital facility maintained by the Veterans' Administration of the federal government at Newington.

Many people in Connecticut do not realize that there are both federal and state hospitals for veterans in Connecticut and that the state itself maintains what is probably the best home for veterans in the entire country.

Other reasons why both these institutions rank so high are found in the individuals responsible for their administration.

The Connecticut Veterans' Home and Hospital at Rocky Hill is operated under the general supervision of a State Veterans' Home Commission appointed by the Governor. The members are: Major Charles H. Sprague, M.D., of Bridgeport, chairman; Walter S. Garde, of Hartford, vice-chairman; William J. Wholean of Hartford, secretary; Samuel S. Mattes of Middletown, treasurer; and Benjamin Stewart of Bridgeport, Major Alvin C. Smith of Milford, and Lt. Col. Allen F. Kitchel of Old Greenwich.

They are men who are vitally interested in the welfare of the veterans of this State and are alive to their responsibilities now and in the future.

### OUTSTANDING ADMINISTRATORS

The commandant of the State Veterans' Home and Hospital is Col. Raymond F. Gates who has been very closely associated with the State's activities for the welfare of veterans over a long period of years.

The Veterans' Home Commission gives Colonel Gates most of the credit for the development and expansion of the State's program for the welfare of its veterans. And other State officials rate Colonel Gates as one of the outstanding administrators in the service of the State. This ability is reflected in the fine staff of officers which operate under him at the Veterans' Home.

In general, the physical facilities which the federal government have provided for the hospitalization of war veterans at Newington are much the same as have been provided in many other states in the nation. But the operation of the Veterans Administration facility at Newington ranks with the best in the country. And this is accredited to the exceptional ability and personality of Manager Myer Schwolsky, a veteran official of the Veterans Administration who rose from the ranks, and the capable and sincere efforts of the subordinate members of his staff, including Vocational Rehabilitation Director John L. Connors who with Manager Schwolsky and Commandant Gates of the Rocky Hill Home serve as active members of the Connecticut Reemployment Commission.

### STATE HOME AND HOSPITAL

The Veterans' Home and Hospital at Rocky Hill is located on a gently rolling hill just outside the center of Rocky Hill. The main buildings, set well back from the highway, present a most attractive appearance from the road.

The site was purchased in 1932 and consists of 310 acres of land and some farm buildings. The present hospital home and administration buildings were completed in 1940 and occupied in August of that year. The hospital building contains beds for 284 medical and surgical patients and the home now accommodates 776 domiciliary cases.

Last month work was started on the construction of an addition to the hospital which will increase its capacity to 612 patients. This work and other new

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construction already authorized is being done with $1,390,000 which was appropriated by the 1943 General Assembly. At present there is pending before the legislature a bill to provide funds which would double the capacity of the home for domiciliary care of veterans in anticipation of the greatly increased need after the present war.

NOT END OF ROAD

Contrary to the old conception of a "Soldiers' Home," Rocky Hill is by no means the "end of the road" for the veterans who go there. Usually, the veterans who seek admission to the home are pretty much alone in the world, unable to earn a satisfactory living by themeselves or are permanently disabled. But the attitude of the administration is that every man who enters the home should be given every possible opportunity to prepare himself to return to normal civilian life. This is accomplished through occupational therapy, vocational guidance and special arrangements with the State Bureau of Vocational Rehabilitation. The occupational therapy program was initiated at the institution by the Connecticut Society for Crippled Children and Adults last July and, having proven highly successful, has now been undertaken as a regular part of the program at Rocky Hill under its own auspices.

For the religious needs of those at Rocky Hill there is both a Catholic and a Protestant chapel. For entertainment there is an auditorium where movies are shown regularly twice a week. Various veteran and civic organizations furnish other forms of entertainment the year 'round.

Hospital patients, of course, leave as soon as the condition they are being treated for is corrected, or it is determined that further hospitalization would do no further good. But those in the home remain indefinitely. In order to keep them partially occupied each man is classified as to types of work he can do according to his physical condition and his abilities. He is then given a regular work assignment. Clothing at the home is an informal uniform. Like every place else, food is something of a problem, but through efficient management and foresight the men at the home and in the hospital fare better than most civilians, even though the cost per meal is modest.

The State Home and Hospital is for veterans of Connecticut only. Men who enlisted while residents of the state or have resided in the state for two years since being discharged also are eligible for admission.

COMPLETE COOPERATION

A close working relationship exists between the State Hospital and Home at Rocky Hill and the Veterans Administration hospital at Newington. Veterans who are eligible for hospitalization at Newington are admitted to the hospital at Rocky Hill under an arrangement whereby the federal government pays the state $300 per annum per patient.

At present the State is collecting about $80,000 a year for the care of veterans who are eligible for treatment at Newington. In general, the State's program is designed and operates to supplement the facilities and services furnished by the federal government both in hospitalization and the welfare of veterans and their wives, widows and dependents.

The latest biennium report of the Veterans Home Commission showed that 3,989 Connecticut veterans received hospital and domiciliary care for those two years. In the same period allowances of $14,607 were paid to 85 widows of Civil War veterans, $24,426 to 124 widows of Spanish-American War veterans and $43,179 to veterans and dependents in general. Burial allowances were allowed in 785 cases and 697 applications for the furnishing and erecting headstones were approved.



ROCKY HILL HOME AND HOSPITAL

VETERANS' ADMINISTRATION HOSPITAL

The Veterans Administration hospital at Newington also is located on a slight hill a short distance from the center of the town with buildings set well back from the road.

The site consists of 208 acres of land, and besides the main hospital and regional office building there is a nurses' home and living quarters for Manager Schwolsky and some of the other officials.

The hospital is complete in every respect with separate rooms for all the various divisions of medicine and therapy. The present war has almost doubled the demands on the hospital with about 40 per cent of the patients now being treated veterans of World War II. Of 2,781 patients admitted last year, 1,129 were veterans of this war. The original capacity of the hospital was 336 patients. To meet increased demands alterations have been made to provide 137 emergency beds. But the number of beds is still far from adequate, and work is to start soon on an addition which will provide 218 more beds, and enlarged surgical and laboratory facilities.

Recently the Veterans Administration and the operation of some of its many hospitals has come in for some criticism. An inspection of the hospital at Newington indicates few if any of these criticisms apply there. One of the general criticisms was that food is served cold in some of the hospitals of the Veterans Administration. At Newington patients who are able to go to the main dining hall, even in wheel chairs, are served directly from a piping hot steam table on pre-heated dishes. Food which must be taken to bed patients is carried in cabinets which are pre-heated by electricity and served on pre-heated dishes. When the equipment for pre-heating dishes became inadequate and no such new equipment was available Manager Schwolsky had his mechanical force construct a homemade heating cabinet.

GENERAL ATMOSPHERE GOOD

The general atmosphere at Newington is one of cheerfulness. The 25 physicians and 52 nurses go about their duties unobtrusively but effectively. Meetings of the medical staff are held every week at which one or more members give papers on phases of medicine and surgery of interest to the whole group. At these staff meetings Manager Schwolsky discusses any special problems which have arisen.

For recreation the patients at Newington have reading rooms, a room where various games can be played and an auditorium where movies are shown twice a week and where veteran and civic organizations provide special entertainment regularly. Patients who are able to be up and around are given a wide latitude of freedom.

In addition to the hospital, the facility at Newington has included a regional office of the Veterans Administration which handles all veterans' claims for this area, and carries out an extensive vocational rehabilitation program. Plans are now in progress to move the regional office into Hartford. A more detailed account of the overall activities at the Newington facility was contained in the January, 1945 issue of *Reemployment*.



VETERANS HOSPITAL AT NEWINGTON

## Captain Stewart Awarded Bronze Star Medal

The following citation was recently received by Mrs. Stewart from her husband, Captain Lester Q. Stewart of West Hartford. Award of Bronze Star Medal—Under the provisions of AR600-45, 22 September 1943, as amended, and pursuant to authority contained in Memorandum Number 34, Headquarters Ninth United States Army, dated 8 September 1944, the Bronze Star Medal is awarded to:

Captain Lester Q. Stewart, 0506790, Medical Corps, for meritorious achievement during the airborne operation across the Rhine River beginning 24 March 1945. After landing by glider near Heiderett, Germany, Captain Stewart's leadership and organizational ability made possible the speedy establishment of an aid station which treated and cleared more than one hundred casualties in the first few hours. His superior performance under difficult tactical conditions enabled many men to receive medical attention in a minimum of time. Captain Stewart's aid to a wounded officer while under enemy fire typified his high sense of duty and personal courage. His actions were in keeping with the highest standards of military conduct. He entered military service from Connecticut.

## Major Wilbur D. Johnston Awarded Bronze Star

Major Wilbur D. Johnston, of New Haven, has been awarded the Bronze Star for meritorious achievement in connection with military operations against the Japanese on Luzon Island in the Philippines.

A veteran of 30 months overseas, Major Johnston has participated in action against the Japanese in four campaigns—Guadalcanal, Northern Solomons, New Guinea, and Luzon.

Prior to entering the Army, Major Johnston was a practicing physician in New Haven.

## Lieut. J. Mignone Returns From Pacific War Zone

Lieut. Joseph Mignone, USNR, recently visited New Haven on leave after spending 15 months in the South Pacific and Philippines as a naval doctor. Attached to a PT boat squadron of the Seventh Fleet, he took part in the invasion of Leyte. Prior to that he participated in the invasion of the Admiralty Islands, and served at advance bases on New Guinea. Dr. Mignone carries three battle stars on his ribbons. While chief of medicine at an advanced naval base hospital at Manos in the Admiralties he made some special clinical studies of tropical disease very prevalent in that area. Before entering the Navy in March of 1943, Dr. Mignone was a member of the staffs of the Grace and St. Raphael Hospitals, and held the rank of clinical instructor at the New Haven Hospital as a member of the medical staff of the Department of University Health.

## Captain Carbone Awarded Purple Heart and Bronze Medal

Captain William C. Carbone, formerly a general practitioner in Hamden, has been awarded the Purple Heart and the Bronze Medal for meritorious service while on active duty with the 9th Army in the European theatre of war. Dr. Carbone has been in the AUS on overseas duty for over two years.

## Captain Receives Chinese Grand Star of Honor

Captain Benedict Biondi, son of Mrs. Ralph Biondi, 164 DeWitt Street, New Haven, and one of the relatively few Americans ever to receive the Chinese Grand Star of Honor medal, is on duty at a field installation of the Chinese Combat Command.

Americans of the Chinese Combat Command, under Major General R. B. McClure, work very closely with Chinese armies, divisions and smaller units under General Ho Hing-Chin, Supreme Commander of the Chinese Army, in the war against Japan's great continental military power in China.

The mission of CCC is to advise and assist Chinese forces in prosecuting aggressive warfare against the Japanese. This liaison is concerned primarily with the planning and execution of field training and tactical operations and with the receipt, distribution and assignment of American equipment and supplies for Chinese military units.

Captain Biondi was presented with the Chinese Grand Star of Honor medal for outstanding and distinguished service rendered by him to the Republic of China and to the Chinese army, upon recommendation of the Chinese general officer commanding a unit with which this American was on duty for an extended period. As a member of CCC, he has for some time been engaged primarily in teaching Chinese troops the methods of modern warfare.

Biondi is a graduate of New Haven High School and the University of Alabama, where he participated in football. Graduating from Tufts Medical School, Boston, he took up private practice of medicine in New Haven. He also served as a staff member of St. Raphael's Hospital.

## Colonel Bizzozzero Granted Audience With Pope

Colonel Orpheus J. Bizzozzero of Waterbury was recently granted a private audience with Pope Pius XII. Colonel Bizzozzero has been named to head the Allied Military Government's Health Commission for the Milan region. He served with the AMG in Rome and while there had a previous audience with the Pontiff.

## Army Service Forces
## First Service Command

**Wac Recruiting Service at Large SCU 1117**
**U. S. Army Recruiting - New Haven District**
**160 Temple Street, New Haven, Connecticut**

April 23, 1945

Dear Dr. Barker:

Recruiting for the Medical Department of the Women's Army Corps is now in its final stage of completion. This drive would have undoubtedly continued indefinitely had not our campaign successfully reached its quota as soon as it did. Actually the figure reached was 185 per cent of the original goal set for our territory.

We recruiters are proud of attaining that success, but we fully realize that without the splendid cooperation of you and other leaders in the State of Connecticut, it would have been impossible to publicize our urgent need, and also gain the support of officials engaged in private enterprise as well as in public service.

Your contribution at a time when it was most needed was far and beyond your patriotic duty. The time, energy, and patronage you so generously gave to our national emergency confirms my belief that here in the State of Connecticut are some of the finest Americans in the country.

I am sure that somewhere a wounded soldier of ours will return to health more quickly and eventually revert to his civilian status as a happy, useful member of the community because there are folks like you who care what the destiny of our country will be.

For the Women's Army Corps and for myself, kindly accept our most sincere thanks.

Cordially yours,
Jane H. Heald,
Captain, WAC
Dist. Rctg. Officer

## Medical Officers For the Navy

Vice Admiral Ross T. McIntire, Surgeon General of the Navy and Chief of the Bureau of Medicine and Surgery, announced that the Navy's recent Nurse procurement campaign produced applications from nurses in excess of the number needed to meet the Navy's urgent need for 2,500 nurses.

"Admittedly the Navy's needs were far less than the Army and Veterans Administration, each of which has need for several thousand more nurses," Admiral McIntire said. "The Navy appreciates the prompt response from the more than 3,000 nurses who applied for the Navy Nurse Corps Reserve as a result of its appeals. Those nurses who cannot be appointed immediately by the Navy, are being referred to the other agencies of the Government so desperately in need of nurses."

The 2,500 nurses currently being selected and appointed from the applications received will enable the Navy to maintain its pledge to provide the best possible medical care for its men and women. A few additional nurses will be commissioned in the Navy Nurse Corps from month to month in the future in order to meet current needs so the Navy program is not definitely closed," the Admiral continued. "It is my understanding that the Army needs approximately 12,000 more nurses immediately. Every eligible nurse should be urged to apply to the Red Cross or Army for the Army Nurse Corps."

The Admiral further emphasized the Navy's immediate need for 4,000 more doctors to meet current and projected requirements. "As our combat forces throughout the world penetrate more deeply into the inner strongholds of the enemy, the battle will become more intense and the casualties greater," Admiral McIntire stated. "The Navy's medical officers are already assuming a tremendous burden and additional doctors must be procured if adequate medical care is to be provided. The increasing tempo of the prosecution of the war will place even heavier demands on our medical officers. The extraordinary record established thus far in the care of casualties is a tribute to the skill of the Navy's doctors and more are needed if this is to be maintained."

Physicians interested in applying for commissions in the Medical Corps, United States Naval Reserve should contact the Procurement and Assignment Service Office, 258 Church Street, New Haven, Connecticut, telephone New Haven 5-0836.

*An open letter to Vice Admiral Randall Jacobs, Chief of the Bureau of Naval Personnel, from the Chief of the Bureau of Medicine and Surgery, Vice Admiral Ross T. McIntire, MC—USN.*

## Admiral McIntire Emphasizes the Need for Far More Physicians and Surgeons

4 May 1945

Vice Admiral Randall Jacobs, USN
Chief of the Bureau of Naval Personnel
Navy Department
Washington 25, D. C.

Dear Admiral Jacobs:

May I take this opportunity to express to you the thanks and appreciation of the Bureau of Medicine and Surgery for the splendid record thus far attained by the Procurement Division in obtaining medical officers for the Navy.

The need of additional medical officers to meet the requirements of the service continues to be a matter of utmost importance, and it is hoped it may be possible to obtain an additional 4,000 as soon as possible.

All medical department personnel, including medical and dental officers, officers of the nurse corps, officers of the hospital corps and the men and women of the enlisted hospital corps branch are rendering most valuable service to our sick and wounded and to our returning prisoners of war. The high standard of care and treatment which the Navy provides for its personnel will be maintained. To do this effectively it is essential that assistance in the form of additional medical officers be obtained for the 13,000 we now have on active duty.

Service in all specialties is available for physicians who meet the physical and other requirements for appointment, and in so far as it is practicable, preference of duty will be given medical officers when they are qualified for the assignment requested.

The sacrifices which an individual and his community must make in order to provide additional doctors for the medical corps of the Navy is appreciated. It is believed, however, that adjustments can and will be made in order that our present and anticipated casualties will continue to receive the best possible care and treatment. The National and State Procurement and Assignment Committees of the War Manpower Commission have indicated their willingness to cooperate with the Navy and local communities in the endeavor to reduce the present shortage of Navy medical officers. There is no desire on the part of the Navy to embarrass any community in so far as medical attention is concerned, but everyone must realize the importance of successfully completing the war and making a permanent victory possible in the shortest time.

It is hoped the officers assigned to the Procurement Division of the Bureau of Naval Personnel will continue their efforts to furnish full information to any doctor wishing to offer his services to the Navy and will assist him in submitting his application for appointment in the U. S. Naval Reserve.

Sincerely yours,
/s/ Ross T. McIntire
Vice Admiral, MCUSN
Chief of Bureau

## Bradley Field To Be Reduced

Under date of April 30 the Associated Press reported that Bradley Field Army Air Base, a unit of the First Air Force, will be placed on a stand-by status as an Army air training base on May 30. By this it is understood that the field would be retained by the Army with limited personnel so that it could be restored to active service promptly. The 1,800 acre field was established in April 1941 and has served as a training base for fighter planes.

A few days after the above information was released the Associated Press announced that Bradley Field would soon be put in operation as a redeployment center for Army Air Force flyers returning from the European theatre, most of whom probably would subsequently be employed in the Pacific campaign. The reprocessing is to consist of a preliminary medical examination, interviews in which personnel records would be brought up to date, and payment made of any such in arrears. It is reported that in most cases returning flyers will leave Bradley Field on furloughs, preparatory to assuming new assignments.

This is the second Connecticut installation of the Air Force to undergo a change within recent months. Only a short time ago the Army Air Force Station Hospital at New Haven was closed. Both these installations were served by local physicians in carrying out the program of monthly meetings

under the direction of Wartime Graduate Medical meetings, sponsored by the Army, Navy, American College of Physicians, American College of Surgeons, and American Medical Association.

## 47% of Medical Officers Plan Home Town Practice After War

Forty-seven per cent, or 9,649 medical officers, indicated that they wished to return to practice in their former communities after the war, Lieut. Col. Harold C. Lueth, Medical Corps, Army of the United States, reports in the April 21 issue of *The Journal of the American Medical Association* in the presentation of an analysis of answers to questionnaires sent to 21,029 medical officers in the armed forces. More than 21 per cent, or 4,310 medical officers, signified that they did not intend to reengage in practice in their former communities.

These findings, Colonel Lueth points out, are important because of the concern which has been expressed about the number of men who will seek licenses to practice medicine after the war. The study was made by the Committee on Post War Medical Service of the American Medical Association in cooperation with the Surgeons General of the Army, Navy and the U. S. Public Health Service and Veterans Administration, and provides information concerning problems that probably will face the various state licensing boards in the future. The 21,029 questionnaires studied represent about 35 per cent of all medical officers on duty.

## Educational Opportunities For Army Doctors

Since the start of World War II, over 6,000 selected medical officers have been graduated from short but intensive courses given by the Medical Department in some thirty critical medical and surgical specialties, according to Major General George F. Lull, Deputy Surgeon General. In addition, refresher courses in general medicine and surgery provide medical officers with a chance to "brush up" before returning to professional assignments after other duty.

Many doctors also benefit while in service from working under key professional personnel in military hospitals. Other medical officers who have been on duty with combat troops in the field are given an opportunity to brush up on their specialty through the rotation policy.

General Lull reported that 350 doctors have been reassigned from field to hospital duty during the past year in the Mediterranean Theater and "the merit of intra-theater rotational plans has been pointed out to other theaters, and is being encouraged in order that the maximum number of doctors might receive refresher training while they are still in military service."

Naturally, professional training of medical corps officers during military service must be restricted to meet military rather than civilian requirements. However, General Lull said, The Surgeon General is keenly interested in the welfare of these doctors and will provide "insofar as is possible" opportunities for professional training.

In the post war period, he added, all doctors will be entitled to professional training, after their release from service, under the G. I. Bill of Rights, and those who remain in the Army will have the opportunity for refresher training at selected military hospitals and civilian schools.

## Favorable Reports On Trench Foot

Reports from the Army general hospitals at Camp Butner, N. C., and Camp Carson, Colo., which are trench foot treatment centers, indicate that the cases now under treatment are for the most part mild. Lieutenant Colonel Roy H. Turner, MC, acting director, Medical Consultants Division, Office of The Surgeon General, who recently returned from an inspection trip, stated that, with the exception of a very small percentage of cases, evidence of injury to the feet is slight and recovery is both rapid and exceedingly satisfactory.

The mildness of trench foot cases now being hospitalized is largely due, in the opinion of Colonel Turner, to the Army's intensified education of troops concerning trench foot which has resulted in the prompt reporting of cases, early diagnosis, and immediate treatment.

## Bunyan-Stannard Envelope For Burns

A fabric envelope to enclose and irrigate burns and open wounds, the invention of Lt. Commander Bunyan of the British Royal Navy, has been the means of saving thousands of lives and limbs. After many years of experimentation and study, he discovered that irrigation with sodium hypochlorite could save the lives of many whose wounds and burns were so severe that their cases would have otherwise been considered hopeless. The dressing

eliminates pain entirely, and can remain on the wound for a period up to three months. A silk manufacturer, Mr. Stannard devoted considerable time and money to perfecting the fabric of the envelope.

The envelope is being widely used by the Allied forces in Asia and Europe, and bomber crews are being supplied with emergency packs that can be applied by the wounded man himself. The fact that it is being used extensively by the American forces is an additional tribute to its effectiveness.

## Expendable Refrigerators Prolong Life of Whole Blood

Whole blood, flown from this country to the European Theater of Operations, keeps in condition for transfusions 5 days longer than formerly, or as long as 21 days, because of a new system of refrigeration inaugurated in April, according to the Office of The Surgeon General.

The bottled blood is now being flown overseas daily in compact, expendable ice-boxes made of metal foil on cotton insulating board which keep the blood within safe temperatures: between 39 and 50 degrees fahrenheit. The containers, measuring 21 x 21 x 25 inches, weigh only 105 pounds when carrying their full capacity of 24 bottles. Each bottle contains about a pint and a half of whole "O"-type blood.

An elaborate system has been set up overseas to complete delivery. The blood is flown to focal points in all forward areas. Blood bank detachments at these points service all Communications Zone medical installations in the area and truck the blood farther forward to advance detachments which deliver it to the operating surgeons.

Brigadier General Fred W. Rankin, USA, Director of the Surgical Consultants Division, Office of The Surgeon General, stated that whole blood plays such a vital role in the saving of lives that anything extending its use is of prime importance.

### NEW TYPE AMBULANCE

An improved ambulance, which will carry twelve instead of four litter cases in greater comfort, has been developed at the request of The Surgeon General by the Ordnance Department in collaboration with the Army Medical Department. By May 31 twenty-five of these new ambulances will be carrying casualties from ships and planes to Army Hospitals.

The new ambulance has an aluminum body with a front wheel drive which allows the bed of the truck to be placed lower, making it easier to move patients in and out. It is smoother riding than the old type and provides such refinements as a heater for use in cold weather, roof ventilating fans to keep the air fresh, window shades to provide privacy in traffic and individual electric lights over each litter. There are ample compartments for bedding and utensils. A comfortable seat is provided the attendant next to the driver. Both sit enclosed with the patients.

### HARMON GENERAL HOSPITAL IS TROPICAL DISEASE CENTER

Harmon General Hospital at Longview, Texas has been designated for the treatment of tropical diseases. The only other Army tropical disease center is Moore General Hospital at Swannanoa, N. C.

The medical staff of Harmon General Hospital has for some time been engaged in a study of relapsing malaria which has resulted in a permanent contribution to the knowledge of the disease, according to Lieutenant Colonel Francis R. Dieuaide, MC, chief of the Tropical Diseases Branch, Medical Consultants Division, Office of The Surgeon General. This study is now being extended to other tropical diseases which are rare in this country, such as filariasis, schistosomiasis and dysentery.

### ARMY EPIDEMIOLOGICAL BOARD MEETS

The fifth annual meeting of the Army Epidemiological Board was held this month on April 26 and 27 at the Office of The Surgeon General. The meeting was presided over by Dr. Francis G. Blake, dean of the Yale University School of Medicine, New Haven, Conn., who is civilian consultant to the Secretary of War and president of the Board. Activities during the past year were reviewed and plans outlined for the coming year.

The Epidemiological Board is administered by the Preventive Medicine Service, Office of The Surgeon General. It consists of a Central Board and ten Commissions: on Acute Respiratory Diseases, Air Borne Infections, Epidemiological Survey, Hemolytic Streptococcal Infections, Influenza, Measles and Mumps, Meningococcal Meningitis, Neurotropic Virus Diseases, Pneumonia, and Tropical Diseases. The work of these Commissions, however, is not limited to the field indicated by the name but is authorized according to opportunities, facilities and specialties of members.

During the past year extensive epidemiological investigations have been conducted in this country and in several theaters of operations overseas. This work has not only proved of practical value to the Army but has materially increased the fundamental scientific knowledge of the causes and control of infectious diseases among the civilian as well as the military population.

### NEW ARMY GUIDE FOR INDUSTRIAL MEDICAL PROGRAM

The Preventive Medicine Service, Office of The Surgeon General, has announced the publication of a new manual prepared by the Occupational Health Division designed to serve as a guide in standardizing the medical program of dispensaries in Army industrial installations. It is listed as

ASF Manual M210 and is entitled, "Operating Procedures for Industrial Dispensaries."

The foreword points out that an industrial medical program has as its mission not only emergency medical and surgical treatment but also the reduction of absenteeism through a well rounded preventive medicine program. The manual then takes up in detail such topics as, "Organization," "Industrial Hygiene Engineering Service," "Relationship with Civilian Personnel Department," "Preventive Medicine Program and Job Assignment," "Emergency Medical and Surgical Care," "Employees Returning from Sick Leave," "Records and Reports," and "Industrial Dispensary Buildings."

The new manual has already been acclaimed by the Civil Service Commission and several other interested organizations as a distinct forward step in industrial medicine generally.

### DISTRICT MEDICAL SOCIETY HONORS GEN. IRELAND

Major General Merritte Weber Ireland, USA, retired, who modernized the Army Medical Department when he became Surgeon General after World War I, received his second honor of the year this month: a citation awarded by the Medical Society of the District of Columbia for distinguished services to humanity and military medicine.

The ceremony was attended by the present Surgeon General of the Army, Major General Norman T. Kirk, USA, distinguished medical officers from the Army, Navy and Public Health Service, and other prominent physicians and scientists.

General Ireland, who was born 78 years ago in Columbia City, Ind., was graduated from the Detroit College of Medicine in 1890, served as Chief Surgeon of the AEF in France during World War I, and as Surgeon General of the U. S. Army from 1918 to 1931.

Previous honors accorded him include the William Freeman Snow Medal, the U. S. Distinguished Service Medal, Companion of the Order of the Bath (Great Britain), Commander of the Legion of Honor (France), the Serbian Red Cross Silver Medal and the Polish Polonia Restituta.

In accepting his newest award, General Ireland urged his associates to seek longer internships for young medical graduates.

### Promotions — Changes of Station

The War Department has announced the temporary promotion to Colonel of Lieutenant Colonel Victor G. H. Wallace of Darien.

Major Ralph E. Costanzo, AUS, Stamford, is now stationed at the Station Hospital in Fort G. H. Wright, New York.

Lieutenant Peter J. Lehndorff, AUS, Willimantic, has been promoted to Major.

Lieutenant Samuel Nesbitt, USNR, New Haven, has been transferred to the Navy Department Bureau of Medicine and Surgery, Research Division, Washington, D. C.

Word has just been received that Lt. Comdr. Robert A. Goodell, Hartford, has been assigned to Special Augmented Hospital No. 4 and assigned to the Pacific Area.

Capt. Frederick C. Weber, Jr., AUS, Greenwich, has been promoted to Major, stationed overseas.

Lieut. Robert Hepburn, USNR, Hartford, is now stationed at the Brooklyn Navy Yard awaiting the commissioning of a new hospital ship to which he has been assigned.

Capt. Burwell Dodd, AUS, Hartford, has been promoted to Major according to an announcement by the War Department. Major Dodd is stationed at the U. S. Army Regional Hospital, Waltham, Mass.

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Captain William B. Scoville, AUS, Hartford

Since my news letter of one year ago I send additional news of neurosurgery in an Army hospital within the continental limits of the United States.

I remained at a neurosurgical center in the Northwest for one year and since May 1944 have been at another new center in the Northeast. Neurosurgery within the continental United States has grown gigantically during this past year with an increase in neurosurgical sections from an average of 50 beds to 600 beds and soon to 1,500 beds. There has been an increase in operations from 3 to 5 a week to 3 to 5 a day. Approximately 70 per cent of these are now peripheral nerve cases with secondary orthopedic complications. Much of interest has been learned but confusion still exists among studious neurosurgeons as to the optimum methods of repair.

Nerve grafts have held the center of the stage

during this past year. Preserved non frozen cadaver grafts are almost certainly worthless; fresh homogenous grafts from amputated limbs probably fail to restore function, as shown by the group studied and published at Walter Reed General Hospital. Autogenous fresh grafts restore sensation in small nerve defects of the hand but so far there is no proof that they restore motor function in the larger defects in nerves of the arm or leg. Preserved homogenous frozen grafts are being elaborately studied at Walter Reed and Cushing General Hospitals. It is too early to tell results, but certainly one's fingers remain crossed.

Tantalum cuffs leave a glistening vascular bed and prevent adhesions so long as they are left in, but break into pieces in the presence of joint motion, and there is no proof that adhesions do not reform following their removal.

Certain neurologists and neurosurgeons are studying nerve electrical conduction by use of needles inserted in the nerve above and below the site of injury. This work may prove of great value in pre- and postoperative diagnosis and therapy. 213 nerve operations have been done at this center in the past 8 months with 98 sutures, 64 neurolyses, 17 grafts, 16 inoperable and 13 normal.

Cranioplasties with tantalum plates remain a big item. So far in this neurosurgical center there have been few epileptic convulsions appearing early following serious brain injury cases from overseas, and resection of brain scar tissue has been done only in those cases showing bone fragments imbedded in the brain (3 in number). A small series of cases followed for a year in the English Army resulted in epilepsy in 25 per cent of the cases. A total of 56 cranioplasties have been done during the past 8 months at this center.

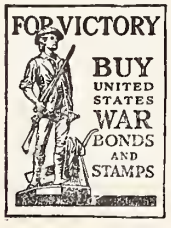
Monotonously, ruptured discs continue a cause for discharge of enlisted personnel and rarely result in return to full duty. In contradistinction the results are excellent in officer personnel. Seventy-five ruptured disc operations have been done at this center over the past 8 months. Myelography fails to diagnose laterally placed lumbosacral discs in at least 20 per cent of cases.

Sympathetic surgery has become increasingly important in the treatment of trench foot, frostbite and traumatic causalgias. Much research should be done in this field to determine if sympathectomy will stimulate the formation of collateral circulation and will lessen the chance of pressure sores on anesthetic feet. Twenty sympathectomies have been done here over the past 6 months.

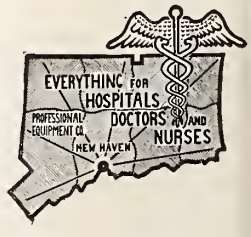
The most tragic of all cases to date have been the spine injuries with transected cords. There have been some 36 cases at this center on which elaborate studies have been made. Roughly ⅓ have had transected cords; ⅓ severely contused cords and ⅓ grossly normal cords at operation. Unless a "flicker" of motor function was present on arrival at this hospital, no late improvement over 6 months follow up has been noted, regardless of the gross condition of the spinal cord. Most of the cases have returned with very large bed sores incurred in the exigencies of transportation. Much has been learned in the treatment of these decubiti. Urea crystals, penicillin jelly and sulfa wet dressings have all been beneficial. Best results have been obtained from granulated sugar plus penicillin jelly dressings, followed later by secondary closure of the deep ulcers, using tantalum wire, and penicillin both locally and intramuscularly. Bladder function has required at least 6 months to return to the point of automatism. Tidal drainage has been universally used, but even so periodic renal infections result. Walking caliper braces have been fitted, enabling even the totally paralyzed patient to begin to stand and walk a few steps but rehabilitation will be a long and tedious process.

Brain and spinal cord tumors are extremely rare in Army neurosurgical centers.

William B. Scoville

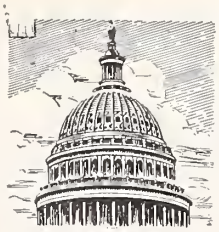



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(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## ON CAPITOL HILL

By the time this is published the 1945 General Assembly of Connecticut will have adjourned unless the puerile device of setting back the Capitol clock is extended beyond what the conscience should allow. It is of course too early to say what the session will finally accomplish but some pretty good guesses can be made. The sum total will probably be very little.

It has not been uncommon in late years for the Senate and House to have different partisan majorities and this year was no exception. The House, as is usual, was overwhelmingly Republican, largely representative of agriculture, conservative and reasonable. There was a substantial Democratic majority in the Senate, including a number of new-comers, and aside from certain selfish job-seeking motives it has not been clear what the senatorial policies were. This partisan division has existed many times before and somehow out of it has come a working cohesion. That did not seem to develop this year. Perhaps leadership was lacking and the peculiarly split election of 1944 which returned Governor Baldwin to the Executive Chambers but elected Democrats to all of the other offices no doubt had a considerable influence. Whatever the cause, the two branches of the Assembly found it hard to reach agreement.

There were more health and welfare bills introduced than in other recent sessions. Some of them were good progressive legislation and projects in which the State might well be interested. Some were badly conceived and others were clearly "crack pot." As it looks from here hardly any are doing well but a change of heart may develop before adjournment.

The proposals from the Public Welfare Council relative to the care of the chronically sick received a good deal of smart and pertinent attention. These proposals were embodied in House Bill 144 which has been changed and modified by the committee in conference with outside persons and at this writing has not been reported out by the Committee on Appropriations. The measure may not be ideal and has elicited criticism but it is a start on a program in which the State must be interested ultimately.

Bills that would provide for the creation of psychiatric out-patient clinics and psychiatric services in voluntary hospitals at state expense are running into a good deal of confusion. They were all reported unfavorably but a new proposal, arising in committee, is rumored and no one can tell now what will become of it.

The fantastic health insurance bill has had an unusual partisan course. In the past when health insurance has been before the Connecticut General Assembly it has been advocated by liberal social planners of every party. This year it became a frank labor measure with strong Democratic support in the Senate. Both committees that heard the bill, Insurance and Appropriations, split on their approval. The House members disapproved in both instances and the majority of the Senate members approved. It is generally accepted by wise veterans around the Capitol that the whole transaction is setting up political timber for the 1946 campaign. The part in the picture played by Miss Connors, defeated candidate for Congress from the Fourth District, has been unique and interesting.

Some things were surely accomplished. The use of x-ray by beauticians for removal of superfluous hair and blemishes was interdicted. Demerol was added to the list of drugs to be sold only on physicians' prescriptions. An amendment providing that only graduates of approved medical schools may serve as interns in Connecticut hospitals has passed the Senate and will probably become a law. This restriction is presently carried on under an opinion

from the Attorney General and its inclusion in the Statutes is desirable.

The final report on legislative action will be available later.

## Cross Currents in Washington

Good observers in Washington are aware of the changes taking place under the new president. This is particularly true in connection with social legislation which was once so near and dear to the New Deal. All agree that Mr. Truman is out to win the war as quickly as possible and return the country to what has long been recognized as the American Way. It has not all been accomplished yet but smart people in Washington see it that way. As one long time student of Washington affairs writes, "The dreamy eyed ones are now taking their eyes from the stars from time to time and glancing at the exchequer and tax bill. That is a good sign." Already Senator George, of the Committee on Ways and Means, has stated that there must be a tax reduction before Japan is defeated and there is growing sentiment that the increasing of Social Security taxes, particularly to include national health insurance, must at least be postponed.

The Hale-Burton Bill that would provide some funds for studies of the distribution and adequacy of medical care in the United States is still in committee and its support is increasing from important sources in medicine.

Mr. Dingell's reintroduction of the 1943 Wagner Bill has not caused much of a sensation and the contents of the new Wagner bill are not available.

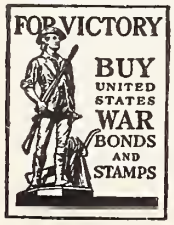
Hearings on the Ellender Bill to exempt medical and premedical students from Selective Service has set off some fireworks. Dean Rappeleye of the College of Physicians and Surgeons at Columbia was not in agreement with his colleagues as to the necessity of such legislation. It does seem likely that there will be a gap in the classes entering medical schools when both the Army and Navy give up their training programs unless sure provision is made for the deferment of medical and premedical students. If a broad interpretation is given to amendment to Selective Service-Local Board Memorandum 115, it would seem that deferment can be obtained thereby and specific legislation protecting such students should not be necessary.

HR 2550, establishing a National Neuro-Psychiatric Institute, as a part of the United States Public Health Service and providing for and aiding in coordinating research relating to neuropsychiatric disorders and for more effective methods of prevention, diagnosis, and treatment of such disorders. It would enable states to initiate service to patients in outpatient clinics and provides for the training of personnel for such clinics. The measure further includes a central research hospital in the U. S. Public Health Service Units at Bethesda and for grants-in-aid for research under other auspices such as hospitals, universities and clinics. The administrative responsibility for this work would be vested in the U. S. Public Health Service and real authority would be given to a special Professional Advisory Council which would pass on all projects. Grants to states would be channeled through state health departments as is customary under public health administration.

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## United Public Health League Enlarges Its Membership

At the annual meeting of the directors of the United Public Health League recently held in Salt Lake City a resolution was adopted to request the official participation of seven additional Western States in the League. These States are Oregon, Washington, Montana, New Mexico, Wyoming, Kansas and Nebraska. At present the League includes Arizona, California, Colorado, Idaho, Nevada and Utah. Mr. Boyle, the Washington representative of the League, reported that the trend for social legislation in Washington seems to have passed its peak and started downhill. Major emphasis is now on winning the war, with social problems left for later consideration.




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(SEE PAGE 2)

# ANNUAL REPORTS

*(Continued)*

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

### 1944 - 1945

### Report of Secretary

Mr. President and members of the House of Delegates:

This is the fourth annual report to be presented to the Society while our country is engaged in war and even though we have not been fully conscious of it, the affairs of the Society have been deeply influenced through those years.

In spite of the uncertainties of the times, and the absence of many active members, the period covered by this report has been rich in achievement for the Society and several projects that had long been under consideration have taken definite form. I refer to the organization of the Woman's Auxiliary which has become an accomplished fact and a notable success since our last annual meeting. The enthusiasm displayed in its organization has been especially gratifying to those of us who have watched and aided it and there can be no uncertainty as to the wisdom of its establishment or the scope of its usefulness. Next I would refer to the Building Fund which I presume will be reported on later by the Chairman of its Board. The steady advance of this ambitious undertaking is another evidence of the Society's willingness to progress. And finally, after many years of study and indecision it now seems assured that a prepaid medical service plan under the auspices of the Society will become a reality. No one who is not thoroughly informed on this subject can appreciate the complexities of it or the responsibilities that the Society has assumed in embarking on such a plan. It is a business operation of a kind and of a magnitude that is new to the Society and while a knowledge of experience elsewhere impels caution, it is in good hands and we shall look forward to its development with confidence.

The membership in the Society has shown a small net increase during the year, which when all the factors involved are understood is a rather remarkable achievement. Each year since 1937 I have been able to report an increase in membership. Today the Society has 2,075 members, the largest number it has ever had. 568 members of the Society entered the service of our country, of these 5 have died while in service, 41 have returned to civil life and others are returnng month by month. As these men have come home it has become apparent that resettlement and readjustment in civil life presented difficulties for some of them and that no agency was as well qualified to aid them in understanding and resolving the problems of their future as the State Medical Society. The Council has authorized the organization of a Service Bureau for returning medical officers and it is already operating as a functional unit.

The Bureau will provide facts and suggestions concerning opportunities for general or special practice in rural or urban communities within this state and information about openings in full time employment, in public service, hospitals and industry. Many young officers leaving the service who have never been in individual practice will wish to resume and extend their professional education and the Bureau is prepared to furnish data concerning residencies and fellowships in Connecticut hospitals and in hospitals located in other states. Details of procedure for application for appointment to such residencies and fellowships are available and whenever possible direct contact is made with hospitals and medical schools by the Service Bureau. Public Law 346, "The G. I. Bill of Rights," applies to discharged medical officers the same as to other veterans. The Bureau is becoming familiar with this law, especially its provisions relating to education and loans, in order that information on these subjects may be given clearly and promptly to returning medical officers. A close working relationship is being developed with the Veterans' Administration so that the somewhat unique problems of physician-veterans may receive appropriate consideration. The Bureau is operated from the executive offices of the Society and its policies will be made by the Council. And in addition, advice will be sought from members of the Society who have already been discharged from

military service and who understand the physician-veterans' philosophies and needs.

The carrying out of these projects and the other varied activities of the Society requires the time, initiative, and skill of many people. The Council of the Society oversees and integrates all of its affairs and under the leadership of its Chairman and the President of the Society has held its regular and some special meetings throughout the year. To your self-sacrificing elected representatives on the Council, the members of the Society owe a deep obligation. Each year there are changes on the Council and it is with regret that we see members leave this well coordinated team, but newcomers with fresh points of view and stimulation are always welcome and soon fit themselves into the democratic mechanism by which the Society is administered. Dr. Jarvis, Dr. Landry, and Dr. Russman will be succeeded by others on the Council in the coming year and their places will not be easy to fill, but we anticipate the abilities of their successors with assurance.

Because of the nature of their activities, certain of the Society's committees are faced with unusual responsibilities and the Committees on Public Health, Industrial Health, and Prepaid Medical Service should be mentioned particularly. These, under the chairmanship of Dr. Colwell, Dr. Yeager, and Dr. Root, have carried on with extraordinary ability and I wish to express appreciation of their services.

Another group that is representative of the Society, although actually serving as an official state agency, that deserves commendation is the Connecticut Medical Examining Board. In times like these when the established pattern is disturbed by the ferment of war, the Examining Board is confronted with special problems and pressures to relax the high standard of medical education and licensure for which this state is noted. Let it be said to the credit of this Board that it has met its public responsibilities with fairness and unswerving ideals.

The Society's JOURNAL continues to be one of the outstanding state journals in the country and congratulations are deserved by its editors. It is a growing influence in medical thought and it should be a source of pride to all of us.

The year has brought new and significant developments in the Society's participation in the cancer program. It is still too early to judge the results of these developments and they bring to the Society responsibilities that cannot be taken lightly. Success will come through wisdom and hard work and understanding on the part of all of what the Society is trying to do in the field of cancer study and prevention. The public looks to us for intelligent guidance.

For some time the medical profession in the state has been apprehensive about the practice of osteopathy here. Occasionally this concern has been founded on prejudice and lack of information, but basically it has been real and derived from unhappy events in other states. On at least two occasions in the past the Society has endeavored to develop through a special committee a better knowledge and understanding of the practice of osteopathy in connection with the whole of medical care in our state and the results have not been as productive as might have been wished. The present committee, under the chairmanship of Dr. Carl Johnson, which is studying the subject and which will present its first report later today is one of good promise, its approach to the question has been forthright and unbiased and from its findings we should learn much that will be helpful to us.

It is not easy to present in a report of this kind an adequate discussion of legislative matters as they have transpired during the current session of the Assembly. The State Legislature, as is well known, was sharply divided on a partisan basis and progress by it has not been well organized or coherent. At the beginning there were introduced a large number of measures having to do with health and welfare. Some of these were sound and on them the Society had been consulted before their introduction, others were the usual run of peculiar proposals, not well conceived and frequently of questionable merit. Right now what the accomplishments were cannot be said. We had particular interest in a bill that would establish a permanent plan for the care of the chronically sick, in an expanded program for mental health and in other thoughtfully constructive measures. There is still hope that some of these will be passed. Most exciting perhaps, was a measure to establish a state wide system of compulsory health insurance. It is not the first time that such a bill has been before the General Assembly, but this year it had a different character and it has become a strictly partisan measure. I am quite sure that this Society should never take a partisan position in public politics, but it should be made clear in connection with this health insurance legislation that it has been advocated and furthered by the Democratic Senate

and has been opposed as undesirable and unsound by the Republican lower house.

Although the permanent results from this Legislature measured in actual accomplishments may not be brilliant or lasting, one close to the situation cannot help but appreciate the increasing frequency with which the advice and counsel of this Society is sought on matters that relate to the public health and welfare. This is most encouraging and is evidence of public appreciation of the type of unselfish service that the Society can and is willing to give. Nothing but good can come from this kind of relationship between the medical profession and government.

Occasionally in the past in presenting this annual report some proposals have been made for consideration by the House of Delegates and I wish now to make another. The whole subject of medical care is receiving a notable amount of public thought and the medical profession in its wisdom should lead in molding that thought. It is the oldest, the most important and should be the most respected group concerned with medical care. But there are many other agencies necessarily involved. With some of these we have a relatively close contact and understanding, other potent ones are not as near to us but we are all striving toward the same objective with only traces of self-interest. I now propose that this Society take the leadership in organizing a voluntary and perhaps informal council of influential and farseeing persons interested and engaged in providing care for the sick and promoting the public welfare. Such an organization might be known as the Connecticut Council on Medical Care and included on it should be representatives of this Society, boards of trustees of voluntary hospitals, the nursing, dental, and pharmacy professions, persons engaged in public health activities, and agencies interested in the rehabilitation of veterans, in preventive psychiatry and mental hygiene and other kindred fields. It is appropriate that our Society should assume the initiative and be the powerful influence that it can be in bringing all of these groups together for discussion of problems with which we are all concerned and for which we must either singly, or better all together, find the solution. I respectfully ask that this proposal be given appropriate consideration by the House at this meeting.

Much of the success of our operations devolves upon employees of the Society and I want to express my appreciation for their painstaking and willing help in carrying out everything that has been asked of them. The load of work that is carried by a staff that is sometimes inadequate is always cheerfully and skillfully done and I know that you join me in thanking them for their loyal service.

During the year coming next and others to follow, we will be confronted by many issues of consequence. Civilization is inevitably in a state of flux, medicine along with every other human endeavor. Some of these problems will be in the headlines of the newspapers and will come no closer to us than that. Some which will arise from the urgings of cause-minded propagandists, we must know how to view with fair skepticism. Others will be very real and to meet them straight on we shall need each others help and fine altruism and we shall also need a high degree of common sense.

## REPORT OF THE COUNCIL

The House of Delegates
Connecticut State Medical Society

Gentlemen:

The Council has had a busy and productive year. It has transacted the business of the Society between meetings of the House of Delegates. I am glad to say again that it was not necessary for the Council to act as a Board of Censors or as a Board of Review in malpractice suits. Its chief specific functions have been those of Nominating Committee, and of Finance Committee for the Society. It would be repetitious at this time to detail its entire activities, for the Council's actions and most of its deliberations are promptly reported in the JOURNAL, and the agenda of this meeting are the fruits of its deliberations in the form of recommendations prepared for your consideration and action.

It has been more difficult than usual for the Council to find for the slate of nominations men who will devote themselves to the task at hand with that diligence and wisdom which our members expect. Again and again our thoughts have turned to those who are in the service. It is certain that many of those nominated would be only too glad to relinquish their opportunities in favor of absent members. Till they return, however, we must carry on.

At long last you have been presented with a new set of By-Laws. These are the result of much thoughtful labor. They are streamlined to fit our present needs and we believe they will suffice for some years without major changes. They allow a maximum of local self-government and provide for centralized responsibility and for the necessary authority which should accompany it.

Your attention is again drawn to the extraordinarily close and fruitful relations which the Society holds with all executive departments of the State government. In recent years we have cultivated pleasant and profitable relationships with Industry and we are on excellent terms with Insurance. With organized labor we are not yet en rapport. Much careful thought should be given to this almost unexplored field.

Our Soeiety has been in close toueh with the Conneetieut Hospital Association, joining forees for our annual meetings and for a time in the pages of the STATE MEDICAL JOURNAL, but we as an organization have not developed the kind of elose affiliation which is elearly called for by the trend of the times. It seems likely that S. 191, the so ealled Hill-Burton Bill at present before Congress, will pass and if the enabling aet is passed by our General Assembly as well, a study of hospitalization in Conneetieut will be undertaken. It is evident to anyone who takes the trouble to read the Hill-Burton Bill that sueh an investigation has potentialities whieh would make it highly desirable for us as a State Medieal Society to have the most cordial relationships with the Connecticut Hospital Assoeiation.

We have always dealt with individual hospitals as members of our respeetive staffs and have built up a tradition of self suffieiency, even of isolation, in eonsidering the relationship of the hospital doetor to the hospital corporation. I wish to quote from the newly suggested By-Laws, Article 10, Seetion 3, Paragraph 5: "The Council shall nominate annually to the House of Delegates a eommittee on hospitals to eonsist of not less than six members and shall nominate the Chairman thereof. This Committee shall pursue a eontinuing study of the relation of the medical profession to the operation of publie and voluntary hospitals within this State and shall when indieated eonfer with the State Department of Health and representatives of the Conneeticut Hospital Assoeiation and make reeommendations to the Soeiety." In true medieal fashion we have deseribed the need and have given you the prescription for its cure. It still lies with the Couneil to see that a suitable eommittee on hospitals is nominated from year to year. We feel that the two nomintaions this year are exeellent men for that purpose.

During the past year two important problems whieh might have been undertaken by the Committee on Hospitals were handled by other agencies. First, the as yet unfinished business of the relation of roentgeneologists to the hospital. These negotiations with the Conneetieut Hospital Assoeiation were of neeessity undertaken by the Couneil itself. A seeond item was the development of a curriculum for intern and residency training. This was ably formulated by a special eommittee of the Committee on Medieal Care and Health of the Post War Planning Board, and has been published in the JOURNAL. All but one of the members on that committee were members of this Society and it is not by accident that two of the members of that committee are the nominees for new members of the Committee on Hospitals, and one of them is nominated for chairman. Both of these problems fall in the area of interest of the newly constituted Committee on Hospitals. Concerning the matter of the relation of the roentgenologist to the hospital, the Council has not as yet come to a eonclusion whieh it can report to the House of Delegates. It therefore wishes to report progress on this matter.

The Council has engaged the Second National Bank of New Haven to aet as fiscal agent for the Treasurer. This will at once relieve the Treasurer of the increasingly difficult mechanics of handling the Society's funds and obviate the expense of bonding him for this purpose, and will also provide for a eontinuity of serviee which will be uninterrupted by the ill health or death of a treasurer.

The Couneil has taken, on behalf of the Soeiety, the responsibility for the preliminary steps in formation of the Conneeticut Medical Service, an aetion whieh should be ratified by the House of Delegates. This is clearly our responsibility. We shall get opprobrium for failure but credit for success.

The Couneil has given its approval for the establishment in Hartford for a eonsulting service on hearing aides.

The Couneil has proeeeded with the development of the roster of junior membership and has eleeted members as already reported in the JOURNAL. The editor of the JOURNAL was authorized to charge two dollars for the annual subscription for student members.

The Couneil accepted on behalf of the Society $1500 from the Anna Fuller Fund to be used by the Tumor Clinie. The wise expenditure of money, of whieh there appears to be large amounts, will call for foresight and skill, espeeially in the development of programs that are sound medieally.

A resolution from the New London County Assoeiation concerning the status of physieians under the Compensation Law was referred to the Industrial Health Committee. This matter is still under study.

The Couneil opposed, on behalf of the Soeiety, the extension of serviees eontemplated by a new ruling of the Children's Bureau on adviee of the Advisory Committee on Conneeticut Program for serviees of Crippled Children. A statement on this matter drawn up by the ehairman was transmitted to Commissioner Osborn, and was published in the March issue of the JOURNAL. The objeetionable proposals have been withdrawn by the Children's Bureau.

The Council authorized the establishment in the offices of the Soeiety of a Serviee Bureau for returning medieal offieers. We must care for our returning members and others who seek to settle in Conneetieut.

The Couneil was kept informed during the year of the aetivities of the Post War Planning Board and advice was given to the ehairman of the Post War Planning Board's Committee on Medical Care and Health. The Couneil has provided for eontinuing study on the praetiee of osteopathy and has appointed a committee whieh it is hoped will familiarize itself with the subjeet over the years, so that advice can be given in connection with legislation at any time. The Council appointed numerous medical advisory committees for the Office of Price Administration in connection with rationing restrictions. The Council notes the satisfactory completion of the study of professional liability insurance so that coverage is now uniform throughout the State. The Council provided for proper representation and participation in the Horace Wells Centenary.

The Couneil had referred to it by the Post War Planning Board, the problem of abuse of emergeney admissions to State Hospitals. This matter was referred to the Society's Advisory Committee to the Study on Chronic Siekness. It is known that the matter was given considerable study but no definitive report can be made at this time.

It would be well for the House of Delegates in considering plans for the next few years to bear in mind how long it takes after a great war for society to shake itself down

into normal life. One may even question the desirability of returning to "normalcy". It was well on into 1920 before President Wilson declared the state of emergency terminated after the last war, and it is likely that more than a year will pass after the guns have finally stopped firing before the need for medical officers will be abated. In other words, many of our members and many of our junior members will be a long time in the service and we older men will still have to bear the burdens. Let us hope that our hearts hold out and the arteries of the brain do not become too brittle.

Respectfully submitted,
James R. Miller

## FINANCIAL STATEMENT

### Prepared by
### Seward and Monde
### Certified Public Accountants

April 18, 1945.

Dr. Hugh B. Campbell, Treasurer
The Connecticut State Medical Society
New Haven, Connecticut

Dear Sir:

We have examined the balance sheet of The Connecticut State Medical Society as of December 31, 1944, and we have also made a general review of the operating and income accounts for the year then ended. In connection therewith we have examined or tested accounting records of the society and other supporting evidence without making a detailed audit of the transactions.

*Current Funds:*

Cash in banks which was reconciled and confirmed by direct correspondence with the depositories, is accounted for as follows:

| | | |
|---|---|---|
| Commercial accounts: | | |
| Phoenix State Bank and Trust Co. | $8,782.82 | |
| The Capitol National Bank and Trust Company—Journal revolving fund | 2,000.00 | |
| The Second National Bank and Trust Company—Executive secretary revolving fund | 2,500.00 | |
| | | $13,282.82 |
| Less, overdraft, The Union and New Haven Trust Company | | 1,912.93 |
| | | 11,369.89 |
| Savings accounts: | | |
| The Capitol National Bank and Trust Company | $4,555.06 | |
| The New Haven Savings Bank | 2,671.45 | |
| Connecticut Savings Bank of New Haven | 2,671.46 | |
| National Savings Bank of New Haven | 2,662.62 | |
| Chelsea Savings Bank of Norwich | 2,773.81 | |
| | | 15,334.40 |
| | | 26,704.29 |
| Petty cash—Journal office | | 5.00 |
| Total | | $26,709.29 |

The overdraft in the Union and New Haven Trust Company is the result of drawing month-end checks in anticipation of a transfer of funds from the Phoenix State Bank. The transfer from the latter bank was not made until January, 1945.

The following United States treasury bonds, which include $7,500 purchased during the current year, were examined in New Haven on January 25, 1945 at the Second National Bank:

| UNITED STATES TREASURY BONDS | AMOUNT |
|---|---|
| 2%, 1953 | $2,500.00 |
| 2½%, 1969 | 2,500.00 |
| 2½%, 1970 | 5,000.00 |
| 2½%, 1971 | 2,500.00 |
| Total | $12,500.00 |

The foregoing securities were placed in safekeeping at the time of our examination, subject to withdrawal by the treasurer.

Dues receivable of $3,514.90 for the year 1944 are segregated by counties as follows:

| COUNTY | AMOUNT |
|---|---|
| Fairfield | $ 655.00 |
| Hartford | 1,610.00 |
| Litchfield | 200.00 |
| Middlesex | 150.00 |
| New Haven | 619.90 |
| New London | 280.00 |
| Total | $3,514.90 |

Interest receivable—U. S. Treasury bonds represents December interest coupons which were attached to $2,500 U. S. Treasury 2½'s of 1964-69 at the time of our examination.

Accounts receivable—Journal of $739.24 consist of 1944 advertising accounts which were paid in 1945.

Accounts payable—Journal of $155.07 represents amounts due for reprints, electrotypes, and operating expenses.

The current funds surplus is segregated on the attached balance sheet as General Surplus and Annual Meeting Surplus. Inasmuch as both the Journal and the Executive Secretary's Office receive budget allotments from the General Fund, unexpended allotments formerly shown as Journal Surplus and Executive Secretary Surplus have been restored to General Surplus as of December 31, 1944.

GURDON W. RUSSELL FUND

Cash in the Gurdon Russell Fund was confirmed by direct correspondence and is on deposit as follows:

| | |
|---|---|
| Mechanic Savings Bank | $2,734.11 |
| Chelsea Savings Bank of Norwich | 249.00 |
| Total | $2,983.11 |

We examined the following securities held by this fund:

| Par Value | Value December 31, 1944 Per Books | Market |
|---|---|---|
| $2,000 Consolidated Railway Company (N. H.) 4% debenture bonds, due July 1, 1954 | $ 230.00 | $1,195.00 |
| $1,000 Boston and Albany Railroad Company, 4½% improvement bonds, due August 1, 1978 | 820.00 | 917.50 |
| $5,000 U. S. Treasury bonds, 2¼% due 1959 | 5,000.00 | 5,026.56 |
| Totals | $6,050.00 | $7,139.06 |

During the year under review $5,000 par value of Connecticut Railway and Lighting 4½'s of 1951, book value $5,350,00, were called at 105. With the proceeds thereof, $5,000 U. S. Treasury 2¼'s of 1959 were purchased, and a cash balance of $249.00 was deposited in the Chelsea Savings Bank of Norwich.

O. C. SMITH FUND

Principal and income cash in the Mechanics Savings Bank was verified by direct correspondence.

CLINICAL CONGRESS

Cash as follows was reconciled and confirmed with the following depositories:

| | |
|---|---|
| The New Haven Bank N.B.A.—checking account | $ 419.91 |
| The New Haven Savings Bank—savings account | 3,443.47 |
| Total | $3,863.38 |

The analysis of income and expenses shown on the attached statement was taken from the records of the Treasurer of the Clinical Congress without any verification on our part.

PREPAREDNESS FUND

Cash in the Union and New Haven Trust Company was reconciled and confirmed directly with the bank.

BUILDING FUND

Cash was confirmed by direct correspondence and is summarized as follows:

| | |
|---|---|
| The Tradesmens National Bank—New Haven | $ 6.13 |
| The Union and New Haven Trust Company | 93.87 |
| The City Savings Bank—Bridgeport | 3,960.00 |
| Total | $4,060.00 |

ANNA FULLER FUND

Cash of $725.00 was verified directly with the bank.

Attached hereto are the following statements:
- Balance Sheet, December 31, 1944
- Statement of Current Funds Surplus, December 31. 1944
- Statement of General Income and Expenses,
- Statement of Executive Secretary's Expenses,
- Statement of Journal Income and Expenses, and
- Statement of Special Funds, Year ended December 31, 1944

Very truly yours,
Seward and Monde.

## Statement of General Income and Expenses
### Year ended December 31, 1944

| | | |
|---|---|---|
| *Income:* | | |
| Dues earned, (net of $1,001.25 military exemptions | $29,318.75 | |
| Less, Commissions paid | 1,467.00 | |
| | | $27,851.75 |
| Interest on investments | | 382.01 |
| Miscellaneous | | 65.50 |
| | | $28,299.26 |
| *Expenses:* | | |
| Council | $ 117.40 | |
| Chairman of council | 300.00 | |
| Delegates—A.M.A. convention | 421.42 | |
| Executive secretary annuity | 999.94 | |
| Building fund expense | 229.37 | |
| Professional fees | 360.00 | |
| Committee on industrial health | 149.10 | |
| Tumor committee | 23.04 | |
| Committee on drug addiction | 5.97 | |
| Committee on prepaid medical service | 58.13 | |
| Women's auxiliary | 284.31 | |
| Insurance | 97.10 | |
| Public relations | 78.70 | |
| War participation committee | 27.30 | |
| Taxes | 12.10 | |
| Miscellaneous | 90.34 | |
| | | 3,254.22 |
| Excess of income over expenses | | $25,045.04 |

## Statement of Executive Secretary's Expenses
### Year ended December 31, 1944

| | | |
|---|---|---|
| Secretary expense: | | |
| Salary | $ 8,400.00 | |
| Expense | 600.00 | |
| | | $ 9,000.00 |
| Office salaries | $ 5,044.20 | |
| Less, Receipts for outside services rendered | 263.15 | |
| | | 4,781.05 |
| Rent | | 1,020.00 |
| Light | | 70.45 |
| Telephone and telegraph | | 271.99 |
| Printing and postage | | 312.23 |
| Office supplies | | 113.53 |
| Janitor | | 72.00 |
| Travel | | 113.16 |
| Miscellaneous | | 664.59 |
| Total | | $16,419.00 |

## Balance Sheet, December 31, 1944

### CURRENT FUNDS

| ASSETS | | | LIABILITIES | | |
|---|---|---|---|---|---|
| Cash | | $26,709.29 | Accounts payable—Journal | | $ 155.07 |
| United States Treasury bonds (market value $12,542.96) | | 12,500.00 | Accrued commissions: | | |
| Dues receivable—1944 | | 3,514.90 | Dues—1944 | $ 139.35 | |
| Interest receivable—U. S. Treasury bonds | | 31.25 | Journal advertising | 156.05 | |
| | | | | | 295.40 |
| Accounts receivable—Journal advertising | | 739.24 | Surplus: | | |
| Inventory—emblems | | 2.50 | General | $38,491.65 | |
| | | | Annual meeting | 4,555.06 | |
| | | | | | 43,046.71 |
| Total | | $43,497.18 | Total | | $43,497.18 |

### SPECIAL FUNDS

| | | | | |
|---|---|---|---|---|
| Gurdon W. Russell Fund: | | | Gurdon W. Russell Fund—Capital | $9,033.11 |
| Cash | $2,983.11 | | | |
| Securities (Market value $7,139.06) | 6,050.00 | | O. C. Smith Trust Fund—Capital | 1,478.27 |
| | | $9,033.11 | | |
| O. C. Smith Trust Fund: | | | Clinical Congress—Capital | 3,863.38 |
| Principal cash | $1,000.00 | | | |
| Income cash | 478.27 | | Preparedness Fund—Capital | 59.23 |
| | | 1,478.27 | | |
| Clinical Congress—Cash | | 3,863.38 | Building Fund—Capital | 4,060.00 |
| Preparedness Fund—Cash | | 59.23 | | |
| Building Fund—Cash | | 4,060.00 | Anna Fuller Fund—Capital | 725.00 |
| Anna Fuller Fund—Cash | | 725.00 | | |
| Total | | $19,218.99 | Total | $19,218.99 |
| Grand Total | | $62,716.17 | Grand Total | $62,716.17 |

## Statement of Current Funds Surplus Year ended December 31, 1944

| | Total | General | Executive Secretary | Journal | Commercial Exhibit and Annual Meeting |
|---|---|---|---|---|---|
| Balance, January 1, 1944 | $33,038.84 | $18,355.93 | $ 2,649.51 | $ 8,915.41 | $ 3,117.99 |
| Less, Adjustment of 1943 dues net of commissions | 42.64 | 42.64 | | | |
| | $32,996.20 | $18,313.29 | $ 2,649.51 | $ 8,915.41 | $ 3,117.99 |
| Summary of 1944 transactions: | | | | | |
| Income | | $28,299.26 | | $16,821.85 | $ 3,963.07 |
| Expenses | | 3,254.22 | $16,419.00 | 16,834.45 | 2,526.00 |
| Excess of income over expenses | $10,050.51 | $25,045.04 | *$16,419.00* | *$ 12.60* | $ 1,437.07 |
| Allotment transfers | | *22,600.00* | 18,600.00 | 4,000.00 | |
| | $10,050.51 | $ 2.445.04 | $ 2,181.00 | $ 3,987.40 | $ 1,437.07 |
| Balance, December 31, 1944 before return of unexpended budget allotments | $43,046.71 | $20,758.33 | $ 4,830.51 | $12,902.81 | $ 4,555.06 |
| Return of unexpended budget allotments to general surplus | | 17,733.32 | *4,830.51* | *12,902.81* | |
| Balance, December 31, 1944 | $43,046.71 | $38,491.65 | | | $ 4,555.06 |

## Statment of Journal Income and Expenses
### Year ended December 31, 1944

| | | |
|---|---|---|
| *Income:* | | |
| Advertising (net of commissions of $2,022.57) | $15,082.04 | |
| Subscriptions | 243.00 | |
| Reprints | 1,241.15 | |
| Electrotypes | 157.80 | |
| Single copy | 50.00 | |
| "Essentials of Emergency Practice".. | 19.60 | |
| Miscellaneous | 28.26 | |
| | | $16,821.85 |
| *Expenses:* | | |
| Printing | $ 8,408.61 | |
| Postage and handling | 550.45 | |
| Electrotypes | 453.81 | |
| Reprints | 698.26 | |
| Editors' salaries | 4,000.00 | |
| Office salaries | 1,622.95 | |
| Office expense | 484.16 | |
| Rent | 372.00 | |
| Telephone | 81.98 | |
| Editorial board and meeting expense | 57.80 | |
| Copyrights | 24.00 | |
| Taxes | 10.68 | |
| Refunds | 55.70 | |
| Miscellaneous | 14.05 | |
| | | 16,834.45 |
| Excess of expenses over income | | $ 12.60 |

## Statement of Special Funds
### Year ended December 31, 1944

| | Total | Gurdon W. Russell Fund | O. C. Smith Trust Fund | Clinical Congress | Preparedness Fund | Building Fund | Anna Fuller Fund |
|---|---|---|---|---|---|---|---|
| Balance, January 1, 1944 | $14,369.18 | $ 8,808.99 | $ 1,508.38 | $ 3,766.16 | $ 185.65 | $ 100.00 | |
| Add: | | | | | | | |
| Gifts | 4,710.00 | | | | | 3,960.00 | $750.00 |
| Registrations and luncheon fees | 1,197.00 | | | 1,197.00 | | | |
| Interest on savings accounts | 117.80 | 25.07 | 24.89 | 67.84 | | | |
| Interest on bonds | 445.80 | 445.80 | | | | | |
| | $20,839.78 | $ 9,279.86 | $ 1,533.27 | $ 5,031.00 | $ 185.65 | $4,060.00 | $750.00 |
| Less, Expenses: | | | | | | | |
| Committee expenses | $ 115.67 | | | | $ 115.67 | | |
| Printing, postage and clerical | 371.87 | | | $ 361.12 | 10.75 | | |
| Projector service and screen | 67.50 | | | 67.50 | | | |
| Insurance bond | 12.50 | | | 12.50 | | | |
| Speakers | 31.82 | | | 31.82 | | | |
| Desk charges | 52.00 | | | 52.00 | | | |
| Women's auxiliary | 30.00 | | | 30.00 | | | |
| Rental charges | 219.00 | | | 219.00 | | | |
| Telephone | 8.68 | | | 8.68 | | | |
| Badges | 6.20 | | | 6.20 | | | |
| Bank charges | 12.15 | | | 12.15 | | | |
| Dinner expense | 366.65 | | | 366.65 | | | |
| Reimbursement to Society by Tumor Committee | 25.00 | | | | | | $ 25.00 |
| Moving books from Hartford | 112.50 | 112.50 | | | | | |
| Servicing equipment | 33.25 | 33.25 | | | | | |
| Payment of members dues | 55.00 | | $ 55.00 | | | | |
| Reduction of book value of securities and related expense | 101.00 | 101.00 | | | | | |
| | $ 1,620.70 | $ 246.75 | $ 55.00 | $ 1,167.62 | $ 126.42 | | $ 25.00 |
| Balance, December 31, 1944 | $19,218.99 | $ 9,033.11 | $ 1,478.27 | $ 3,863.38 | $ 59.23 | $4,060.00 | $725.00 |

## REPORT OF THE COMMITTEE ON TUMOR STUDY

Hugh M. Wilson, Chairman

*Executive Committee*

Louis P. Hastings — Stanley H. Osborn
Ralph E. Kendall — Douglas J. Roberts

*Members*

A. Nowell Creadick — Edward A. Lawrence
Thomas J. Danaher — William Mendelsohn
Edward W. Foster — Christopher J. McCormack
Carl C. Harvey — John A. McCreery
Thomas S. Harvey — Berkley M. Parmelee
Kenneth K. Kinney — William C. Welling
Milton C. Winternitz
Creighton Barker, *ex officio*

The Committee on Tumor Study held its annual meeting in the offices of the State Medical Society on September 29, 1944. The Committee reviewed the table of organization of the Connecticut Cancer Program and approved the policy recommended by its Executive Committee to establish an autonomy in the component organizations of the state program.

The co-ordinated cancer program in Connecticut has been developed along three lines of activity: (1) lay education under the sponsorship of the Connecticut Cancer Society, (2) medical service sponsored by the Association of Connecticut State Tumor Clinics and (3) statistical research provided by the Division of Cancer Research of the State Department of Health.

### (1) The Connecticut Cancer Society

This organization and its Field Army, formerly the Connecticut Branch of the American Society for the Control of Cancer and the Women's Field Army, has maintained on its Board of Trustees a majority of its members who are also members of the Tumor Committee. The Chairman of the Tumor Committee has served as President of the Cancer Society since 1941. Since its program sponsors educational publicity and raises funds to aid local, state, and national projects and corresponds closely to the programs of other lay organizations like the National Tuberculosis Society, the Red Cross and the Infantile Paralysis Fund, it would appear advantageous to encourage the development of the Connecticut Cancer Society along similar lines. As a step in this direction a nominating committee consisting of Doctors Foster, Collins and Mendelsohn presented the following slate of officers who were duly elected by the Board of Trustees of the Connecticut Cancer Society at its annual meeting on June 26, 1944:

*President:* Dr. A. Nowell Creadick, New Haven
*Secretary:* Dr. Christopher J. McCormack, Hartford
*Treasurer:* Mr. Charles F. Lewis, Waterbury
*Commander Field Army:* Mrs. Douglass O. Burnham
*Members of Executive Committee:*
Dr. Stanley H. Osborn
Dr. Hugh M. Wilson

The Society has recently undertaken a campaign to raise $170,000 in this state as part of the national campaign of the American Cancer Society to raise $5,000,000 toward an expanded program of education, service and research in the cancer field. This undertaking together with the plan to establish the Society on an autonomous basis requires the services of a full time managing director. When a candidate for the position was found available the Committee decided to provide a grant in aid to the Cancer Society to appoint Mr. Edwin Meiss as managing director.

### (2) The Association of State Tumor Clinics

The Tumor Committee voted to invite delegates from the organized tumor clinics of the state to formally organize an Association of Tumor Clinics under Articles of Association and Bylaws. The Articles of Association were drawn and presented by Dr. Kendall, chairman of the Scientific Committee and were accepted by the delegates at their meeting in New Haven November 9th, 1944. The following officers were elected:

*Chairman:* Donald A. Bristoll
*Secretary:* Robert Tennant
*Members of Executive Committee:*
Samuel C. Harvey
A. Nowell Creadick
Berkley M. Parmelee

A copy of the Articles of Association and Bylaws are appended to this report.

### The Publicity Committee

Dr. Stanley Osborn reported the activities of the Publicity Committee since the last annual report and recommended that the Committee be dissolved since there seemed less for the Committee to do as cancer information was being distributed by the different groups who had their own methods of releasing such information. The Committee voted approval of the dissolution of the Publicity Committee.

### Grant From The Anna Fuller Fund

The Committee was notified by Dr. Barker of the grant of $1500 voted by the Trustees of the Anna Fuller Fund to the Connecticut State Medical Society for work in the field of Cancer Control in this state for the period of November 1944–November 1945. On April 15, 1945, $100 had been spent for secretarial-editorial assistance and a grant in aid of $830 had been made to the Connecticut Cancer Society to underwrite the salary of a managing director for two months. This grant in aid was made to help complete the organization of districts of the Field Army and to aid in the Society's April campaign for additional funds.

### Summary

As a result of the changes noted in this report the Committee on Tumor Study hopes it has achieved a sound position to act as a representative body of the State Society to co-ordinate and advise the various independent organizations that are or may be established to carry on the cancer program of Connecticut.

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## REPORT OF THE COMMITTEE ON HONORARY MEMBERS AND DEGREES

James D. Gold, *Chairman*

Roy L. Leak — George M. Smith

The Committe on Honorary Members and Degrees wishes to nominate for honorary membership in the Society Ross

Granville Harrison, New Haven, A.B., Johns Hopkins University, 1889, PH.D., 1894, LL.D., 1942; M.D., University of Bonn, 1899; honorary SC.D., University of Cincinnati, 1920, University of Michigan, 1929, University of Dublin, 1932, Harvard University, 1936, Yale University, 1939, Columbia University, 1940; honorary PH.D., University of Freiburg, 1929; honorary M.D., University of Budapest, 1935. Associate professor of anatomy, 1899-1907, Johns Hopkins University; professor of comparative anatomy, 1907-1921, Sterling professor of biology, 1927-1938, professor emeritus since 1938, Yale University. Chairman, National Research Council, Washington, D. C.

## Achievements of National Society For Prevention of Blindness

Steady progress in the organized campaign for protection of eyesight in America during the past three decades is reflected in the 30th Annual Report of the National Society for the Prevention of Blindness, made public recently by Mrs. Eleanor Brown Merrill, executive director.

Among the Society's principal activities were the conservation of eyesight in industry; control of glaucoma, a disease which frequently leads to blindness; and promotion of special classes and facilities for the education of children with seriously defective vision.

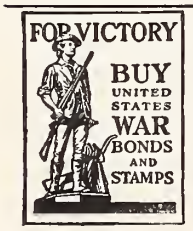
The outstanding development in conservation of eyesight in industry, the report says, is the Society's participation in the War Production Board's drive to speed up production through improvement of visual conditions in war industries. Cooperating in this program are the U. S. Public Health Service; War Manpower Commission; and U. S. Department of Labor. Many industries have availed themselves of a special advisory service on visual problems relating to production and safety which is being offered by the Society, under a non profit contract with the War Production Board, the report points out.

A study of conditions in 150 plants, employing more than 400,000 workers, disclosed the following facts: Only 61 per cent make the preplacement vision tests necessary for correct job assignment; more than 75 per cent of the plants where tests are made fail to have the testing done under the direction of an eye specialist, indicating lack of uniformity, and possible inaccuracy; more than 85 per cent of the plants fail to recheck vision of all employees periodically; more than 80 per cent make no recheck of vision of workers exposed to special hazards; 92 per cent fail to recheck vision of employees with poor production records; 83 per cent do not recheck vision of workers involved in accidents; and 73 per cent make no rechecks where original vision test disclosed need of follow-up.

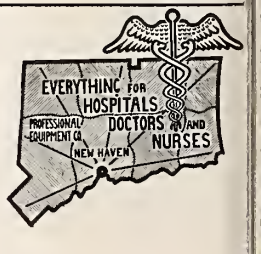
Discussing vocational rehabilitation, the report asks: "If it is possible, in times of war, to utilize defective eyesight with the aid of corrective work goggles, proper lighting, and other mechanical improvements, why could not these principles be applied to the post war program of providing useful work for the returning visually handicapped serviceman as well as for civilians who hitherto had not been able to realize fully their capacity for gainful employment?"

In a preface entitled "Looking Ahead," Mason H. Bigelow, president, says: "The Society is waging its war on preventable blindness in industry, in the home, in the school and in the hospital. Its program of professional and public education has aroused doctors, nurses, safety engineers, social workers, teachers, and parents to do their part in saving sight.

"Since the founding of the Society 30 years ago, the number of children in schools for the blind who lost their sight because of ophthalmia neonatorum has been reduced by 75 per cent; the number of sight-saving classes for school children with seriously defective vision has grown to 613; and programs in industrial safety have multiplied and improved notably. The original band of 10 pioneers who founded the organization has grown into an army of 30,000 members and donors."




THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# WOMAN'S AUXILIARY

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. H. Bertram Lambert, Bridgeport
*Vice President*, Mrs. Creighton Barker, New Haven
*Secretary*, Mrs. Charles W. Goff, West Hartford
*Treasurer*, Mrs. Julian G. Ely, Lyme

## THE ROLE OF THE WOMAN'S AUXILIARY

George H. Carter, M.D., *Willimantic*

Mrs. chairman and members of the Woman's Auxiliary: I wish to extend to you a warm and hearty welcome from the County and State Medical Societies. We anticipate with great satisfaction the help you will undoubtedly give to us during the coming years.

The National organization of Woman's Auxiliaries was founded in 1922. The objectives of this organization were to be "to extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement of health and education; to assist in entertainment at all medical conventions; to promote acquaintanceship among doctors' families so that closer fellowship may exist."

Today 43 states have woman's auxiliaries. Through the coming years there will be innumerable problems facing the doctors of our country. In these your help can be invaluable. The increasing demands upon the doctors, at this time due to so many now serving in the armed forces and in the future due to the tremendous problems of veteran care and rehabilitation, prevent us from giving proper consideration to the many other medical problems which are before us now and will arise in the near future.

Among these problems I might mention only a few.

1. The many medical bills before state and federal legislatures. A large number of these bills are passed or killed without the doctors even knowing of their existence. Many are ridiculous bills presented by small groups of people for various and often vague reasons and these should be exposed or defeated and this can be aided by such organizations as yours. Others are good and well thought out bills which with your help in publicizing can be passed. The physicians themselves for many reasons cannot take an active part in the defeat or passage of these bills nor can they ferret out the facts necessary for the proper consideration of their merits or faults.

2. *Socialized medicine.* For the past number of years the Government has had a finger in the medical pie. Many of the so-called aids to gain better medical care for the public are primarily means of increasing this hold. Which aids are essentially presented to gain this end and which are actually needed and beneficial is a question. Possibly you can help us in analyzing these. What are the pros and cons of socialized medicine in general? The public is only too prone to grasp any plan which on its surface apparently gives them something for nothing or at least less than they think they are paying now. What are the advantages of having as your physician a state paid employee as against one whom you employ as your choice due to his training, ability and reputation? What will be the total cost per person for socialized medical care and what percentage of that cost will be utilized in clerical activities? This problem is not a simple one but one which should be studied by many serious minded organizations, without prejudice for or against the idea at the start, but, with the aim to present to the profession and to the public conclusions backed by facts and not vague and high sounding ideals. These conclusions should be founded on cold facts based on medical knowledge, accounting statistics and the psychology of patients and of physicians.

3. *Prepayment medical and hospital plans.*

This problem alone needs much thought, time and effort, the sifting of experimental attempts and analyzing the whys and wherefores of failures and successes. These are only a few of the many problems I might suggest for your consideration. The actively practising physician cannot possibly give

*Presented at the organizational meeting of the Woman's Auxiliary of Windham County at Putnam, April 6, 1945*

the required time and thought to these problems and we will be dependent to a great extent upon the studies such organizations as yours make to help in arriving at the proper decisions. Our need for your organization will not end with the war but will continue for many years.

In closing let me quote from a talk given by Dr. Knowlton to the Fairfield County Womans' Auxiliary: "Let me ask you to include in all your various activities education as your main objective, stressing the teaching of the fundamental truths of life as exactly as we can determine them; the teaching of tolerance in its broadest sense as the most likely means of promoting peace; and the teaching of health measures as the most likely means of promoting happiness."

## War Participation Committee Active

Mrs. Frank S. Jones, chairman of war participation committee for the state met with members of the executive committee on April 30 at the office of the State Medical Society in New Haven to review news items collected for the second News Letter to physicians in the Armed Forces, which will be sent in May. Assisting Mrs. Jones in collecting this material were: Mrs. Stanley B. Weld of Hartford County, Mrs. William J. Logan of New Haven County, Mrs. Louis Soreff of Middlesex County, Mrs. Chester Haverland of Fairfield County, Mrs. Andrew Laakso of Windham County, Mrs. Julian G. Ely of New London County and Mrs. Donald Herman of Litchfield County.

## Middlesex County Auxiliary Meets

The Woman's Auxiliary to the Middlesex County Medical Association met on April 12 at the Congregational Church in Cromwell. Mrs. Frederick Tracy presented constitution and by-laws, which were approved and adopted. Mrs. H. Bertram Lambert, president of the State Auxiliary, and Mrs. Creighton Barker, chairman of organization committee, addressed the meeting. After the business meeting the members and guests of the Auxiliary joined the doctors for dinner at the Edgewood Country Club.

## Meriden Organizes An Auxiliary

Mrs. George Fox of Meriden called a meeting of Auxiliary members who reside in that city to discuss the idea of forming a city group. The meeting was held at the home of Mrs. M. J. Conroy, 71 Williams Avenue, Meriden. Mrs. Creighton Barker, and Mrs. Luther K. Musselman, president of New Haven County Auxiliary, attended the meeting and spoke informally. Mrs. H. F. Pennington was elected temporary chairman to organize the group. Twenty-six members attended the meeting. Tea was served after the meeting.

## Revision Committee

The revision committee, Mrs. Paul S. Phelps, chairman for the State Auxiliary, met in Hartford to complete reviewing the constitution and by-laws.

## New London County Auxiliary

The Woman's Auxiliary to the New London County Medical Association held its annual meeting on May 16 at the Norwich Inn, Norwich.

## Fairfield County Auxiliary

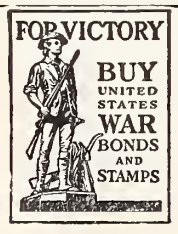
The Fairfield County Woman's Auxiliary held its annual meeting on May 17, at the Stratfield Hotel, Bridgeport.

## Hartford County Auxiliary

The Woman's Auxiliary to the Hartford County Medical Association met on May 9 at the Hunt Memorial Building in Hartford.

## What the Auxiliary Does in Philadelphia

The Philadelphia Woman's Auxiliary publishes monthly a colorful little booklet which brings to its members all the information regarding the activities of the Auxiliary. This same Auxiliary has inaugurated and administered a Student Loan Fund, a revolving fund which has enabled many a student to finish the last year of his training with what *Philadelphia Medicine* calls "a peaceful mind regarding financial matters."




PROFESSIONAL HEADACHES: — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.




(SEE PAGE 2)

# OBITUARIES



## Superintendent O'Brien's Son Killed in Pacific

Lieut. John F. O'Brien, son of Dr. John F. O'Brien, medical director at the State controlled Seaside Sanatorium for tubercular children at Waterford, was among five medical officers and six Army nurses killed April 28, when a suicide Japanese plane crashed on to the stern of the U. S. hospital ship Comfort, 50 miles south of Okinawa in the Pacific.

Lieut. O'Brien had his premedical training at Catholic University, and graduated in December, 1943, from Georgetown Medical School. He served as intern in St. Francis Hospital, Hartford, from January 1 to October 1, 1944, and soon after joined the Army Medical Corps. He trained at Carlisle Barracks, Pa., and at Moore General Hospital, Swannanoa, N. C.

One brother, Capt. Edmund W. O'Brien, of Waterford, is in the Field Artillery, now in Oklahoma, and another brother, Pvt. Donald F. of Avon, is with the Marines in the South Pacific.

The Jap suicide pilot crashed into the Comfort's stern after making several runs, and according to Army officers there was clear intent. The attack was in bright, full moonlight. The hospital ship was brightly lighted, and searchlights were turned on the large, clear markings identifying the Comfort as a mercy ship. The Comfort, loaded to capacity with wounded, was hit less than four hours after leaving Okinawa.



## Dwight H. Stoughton
### 1892 - 1944

The membership of the Hartford County Medical Association finds difficulty in expressing adequately its feelings of regret in the loss of Dr.

Dwight H. Stoughton. He passed away December 16, 1944, at the age of 52 years, which seems untimely, yet he built well for the future and his efforts have left an indelible mark.

A truly magnanimous gentleman, dignified, quiet, of retiring disposition, the extent of his knowledge and interests, the great number and sincerity of his friendships, and the kindness, generosity and strength of his character hardly have been appreciated except by those who knew him well.

He was graduated from McGill University School of Medicine in 1918. He practiced dermatology in Hartford until, during the depression of the 1930's, much against his desire, retirement from active practice was forced upon him in order that his full time could be given to the D. G. Stoughton Co., established by his father in 1875, and which he developed into an outstanding organization serving the community, and more particularly our profession.

Through this work, he became a member of the Connecticut Pharmaceutical Association and the American Surgical Trade Association. He was a member of Christ Church Cathedral, a Past Master of St. Johns' Lodge No. 4, A. F. & A. M., and a 32nd Degree Mason.

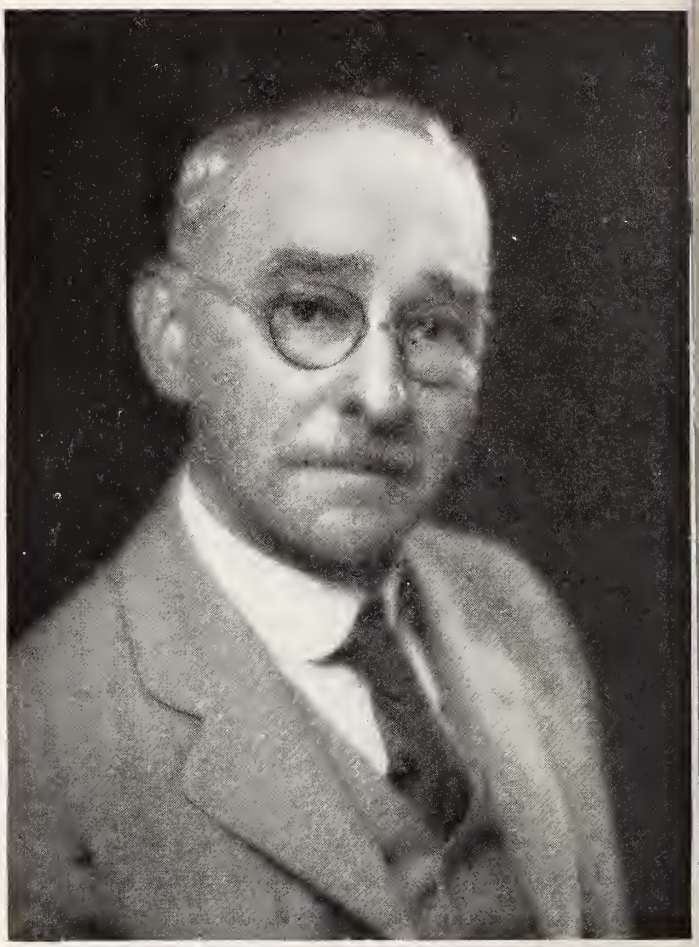
In each of these organizations, as well as the Hartford County Medical Association, his pleasing personality gained for him many friends who will never forget his genial smile, firm grip, and universal benevolence.

R. M. Yergason, M.D.

## Edward Dorland Smith, M.D.
### 1875 - 1945

Dr. Edward Dorland Smith died at the Bridgeport Hospital on February 5, 1945. He was born in Peru, New York, April 29, 1875, son of Oliver Keese and Mary Sarah Dorland Smith. He was a descendent of Caleb Carr, first Governor of Rhode Island, and of Elizabeth, sister of Benjamin Franklin.

Dr. Smith was an ophthalmic and aural surgeon and practiced almost fifty years in Bridgeport. After being graduated from Plattsburgh High School, he entered Yale University and was graduated with Bachelor of Arts degree in 1896; in 1899 he was graduated from Yale Medical School. From 1900-1901 he served his internship at Bridgeport Hospital and then entered general medical practice there in 1901. In 1902 Dr. Smith became assistant to Dr. F. M. Wilson with whom he entered into partnership



Edward Dorland Smith, M.D.

in 1907. In 1902 he was assistant surgeon at Manhattan Eye, Ear, and Throat Hospital, New York City. From 1908 to 1912, he was assistant eye and ear surgeon, New York Eye and Ear Infirmary. In 1905 he became ophthalmic and aural surgeon at the Bridgeport Hospital.

Dr. Smith was a great student and studied extensively in this country, Europe and India. He did postgraduate work at the University of Vienna in 1907, 1909, and 1911. He also did postgraduate work in London, Berlin and Paris. He studied with Colonel H. Smith at Amritsar, India, from 1912-1914. Because of Colonel Smith's vast experience in the removal of cataracts, Dr. Smith spent much time perfecting that operation.

During World War I, Dr. Smith was eye consultant to the local Draft Board and a member of the Medical Advisory Board. In 1919 he took Dr. Edward N. DeWitt into partnership with him.

Although Dr. Smith had been in poor health for some time, he continued in active practice, meeting demands far beyond his strength. Dr. Smith was

admitted to the Bridgeport Hospital on December 12, 1944 after having reported to his office that morning.

His contributions to ophthalmic literature, although not voluminous, were important, especially his thesis on "Cataract Operations" written in 1922. His papers on "Refraction" were always gratefully received by the profession.

Dr. Smith was a member of the American Ophthalmological Society, The Academy of Ophthalmology and Otolaryngology, The New York Academy of Medicine, The American Medical Association, The Connecticut State and County Societies, and The Bridgeport Medical Society, and a member of the Nu Sigma Nu fraternity. He was also a member of the Brooklawn Country Club, The Fairfield Beach Club, The University Club of Bridgeport, the Metabechouan Fishing and Game Club in Kiskisink, Quebec, and of the Society of Friends Club.

He had as his avocation the collection of etchings, many of which came from all parts of the world. He was an incessant reader and had one of the largest private libraries in New England. His knowledge of birds was not amateurish. He was also interested in music, art, and architecture and possessed a complete reference library on each.

Professor Albert G. Keller of Yale University wrote the following tribute:

"Dorland Smith was one of those wholesome and upright characters who are strong enough to lift even the highest and most devoted of human services a degree higher in the estimation of man. His colleagues speak for his professional standing.

"I first knew Dorland Smith in 1892 when we were impecunious freshmen together. For all the years between then and now he never failed to ring true. We became doctor and patient about 30 years ago and have grown elderly together, finding ourselves viewing life through the decades from much the same conclusions.

"There was no trace of pretentiousness in him. He knew what he knew and was quietly firm in his conclusions, however bold they may have seemed to others.

"His attitude was such as to inspire full confidence in him.

"In demeanor Dr. Smith was reserved, he was a listener rather than a talker, a man of sparing and weighty words.

"In short, here was a model surgeon and physician in dealing with the body, and the same high qualities were ever present in his personal relations. He was a wise and just man. To those who knew him the world is the emptier for his passing but the memory of him remains a fragrant gift."

Edward N. DeWitt, M.D.

## Penicillin For Prescriptions

Questioning the advisability of restricting sale of penicillin to prescriptions, Dr. Frederick J. Cullen, executive vice-president of the Proprietary Association of America, in the current bulletin to members, notes that "ample control is assured over the products of this type that are to be distributed to the general public."

At the same time Dr. Cullen urges the industry not to advertise and exploit penicillin in the manner of vitamins.

"Some of the States are attempting to enact legislation which will restrict the sale of penicillin to prescriptions," the bulletin states. "I do not feel that penicillin should be used in proprietary products and then advertised and exploited in the manner that vitamins, for example, have, but is there any good reason why penicillin should be restricted? There has been no evidence made available to show that penicillin is dangerous, regardless of the size of the dosage. Might not this drug be of value in self-medication in preventing the spread of various types of diseases, and thus help in maintaining public health and in building resistance against disease?

"Penicillin has been given consideration by the Federal Food and Drug Administration under the provisions of Section 505 (the new drug section) of the Federal Act, and preparations that are placed on the market containing penicillin will also have to be considered under this section. Therefore, we feel that ample control is assured over the products of this type that are to be distributed to the general public. To deny this contention is to reflect upon the integrity and ability of the members of the Federal Food and Drug Administration. We may safely contend that the facilities and resources available to the Federal Administrator in determining the safety of drugs exceed those available to selfishly interested groups and that a determination by the Federal Food and Drug Administration in a duly promulgated regulation or in the form of an approval of a drug application should be sufficient for the purposes of State enforcing officials."

## Rockefeller Foundation President Is Right

Raymond B. Fosdick, president of The Rockefeller Foundation, in his review of the Foundation's work for 1944 levels a finger directly at the American government for its short sighted policy in regard to the training of scientific men. He is right in so doing as the medical profession to its sorrow will become only too aware of the situation during the next decade. England and Russia have sought to protect their future by guarding the flow of new scientific personnel, whereas Mr. Fosdick finds that the policy in our country seems to have been largely dictated by expediency and the apparent necessities of the moment. "With us, science professors and students alike have largely left the universities. Except for a few 4-F's, we now have practically no male students over 18 studying science."

During 1944 the Rockefeller Foundation has provided a series of appropriations for a fellowship program in the United States that is without precedent in the history of its organization. To date a total of 7,500 fellowships at a total cost of a little over $20,000,000 have been awarded. Now to supplement the provisions of the G. I. Bill of Rights the Foundation has evolved a plan for future fellowships at home in four fields. One of these fields is medicine.

To quote from the 1944 Review: "The program was initiated in December of 1943 when the Foundation appropriated $320,000 to assist the post war training of medical graduates returning from the armed services. An additional sum of $188,000 was appropriated in 1944, making a total of $508,000 for medical training. These actions were based on a recognition of the incompleteness with which young medical men have been educated during the war.

"It is not only that the usual four years of medical school have been telescoped into three, but the periods normally devoted to internships, assistant residencies and residencies in hospitals have been sharply curtailed. In ordinary times, those medical students who survive the successive screening tests have been given a postgraduate period of about five years to gain experience, to mature in knowledge of medicine and to prepare for specialization. It is this period that sifts out and identifies the best men, the men who will be the teachers of the next generation. Under the wartime emergency, the possible five years has been cut to what may be as little as nine months. Men are being rushed into the Medical Corps of the Army and Navy before they have a chance to ripen into the well rounded scientists who constitute our top group in medicine. Those who come back from the war will be older, many of them will have taken on family obligations, and their natural tendency will be to pass on to whatever professional opportunity seems most attractive. The purpose of the Foundation's new fellowship program is to make it possible for 21 leading medical schools to offer a limited number of residencies to the best of these men when their war work is done—residencies which will pay stipends adequate for the individual cases. The selection is now being made by the professors in the medical schools on the basis of their judgment of their own former students. To young doctors in military service such an offer coming at this time will enable them to plan their reading and direct their thoughts to a clearly definable goal, and thus prepare themselves as far as possible for their future posts."

## English Comes First In New U. S. Pharmacopoeia

For the first time, the English language will take precedence over Latin in the U. S. Pharmacopoeia, the official compendium of drugs. After six years of discussion in the U. S. P. Committee of Revision, of which Dr. E. Fullerton Cook is chairman, it was decided that the new Pharmacopoeia, scheduled for publication in December, would carry the English names of drugs first, followed by the Latin. Medical members of the Committee were chief advocates of the change.

The U. S. Pharmacopoeia was first published in the 1820's, and has been published at ten year intervals since. Recently, the Pharmacopoeia Committee decided a new issue should appear every five years, but it is understood that this decision may be reconsidered. Because Latin had been the language of science, it was used in drug and medical nomenclature.

## Group Insurance One of the Answers

The new medical care, prepayment insurance plans, built around a hospital, are not the answer to the Wagner-Murray Bill, according Harold Swanberg, editor of *Mississippi Valley Medical Journal*. On the other hand, Dr. Swanberg believes that widespread group insurance, offering liberal policies free from technicalities and limitation, with *all* diseases and accidents covered, providing loss of time, medical expense and hospitalization benefits, at a reason-

able charge, is one of the answers to the Wagner-Murray Bill. It is his contention that if every worker already had such insurance coverage he certainly would not be interested in paying additional social security taxes to provide the same thing at a greater expense to him.

## Radium Needles in Carcinoma of Bladder

Wayman and Marting of Cincinnati, Ohio, present a new method of treatment of infiltrating carcinoma of the urinary bladder in the *Texas State Journal of Medicine*, January 1945. Either the vaginal or perineal or the suprapubic approach is used, depending on the location of the tumor. Without opening the bladder by either approach, radium needles with a filter of 0.5 mm. of platinum are implanted approximately 1 cm. apart throughout the entire tumor-bearing area. This is a primary treatment and is applicable in inoperable as well as operable tumors. Following out the authors' technique, the removal of the radium needles is said to be very simple. Advantages claimed for this method are (1) the tumor is not cut across, (2) bladder infection is kept at a minimum, and (3) the growing edge of the tumor is attacked early.

## Government Domination

A very interesting document released by the Catholic Hospital Association in collaboration with the Department of Social Action, National Catholic Welfare Conference, is worthy of careful reading. "Catholic Viewpoints with reference to a National Health Program," Bulletin No. 220. A quote from "The Government in the Wagner Bill."

"In the Wagner Bill the Government is given exclusive dominant and coercive power over the health care of the nation. It determines the individuals who are to be general practitioners and who are to be specialists and thereby substitutes itself for those control agencies voluntary in character, which have traditionally supervised medical practice. The Government sets itself up as an educational accrediting agency since while it recognizes the assistance of the supervisory groups over the professional schools in the health field, it still makes a Government official responsible for the application of recognized and accepted standards to the schools of medicine.

"If the accepted system had broken down even at one significant point, there might be justification for the creation of a dominant governmental plan. What seems to have happened is rather this, that under the present emergency when Government must be dominant in so many areas, the opportunity is being seized of extending governmental domination into all areas not as yet brought under complete Governmental Power."

## Passaic County Does Rh Factor Determinations

Due to a request from the Maternal Welfare Committee of the Passaic County Medical Society, the Board of Health of Paterson, New Jersey, began doing Rh determinations as a routine in June 1944, according to a report by Lee, Van Saun, and Brown in the *Journal of the American Medical Association*. Blood grouping was also added. In addition to the ante partum specimens tested, a specimen of blood from the husband is also requested and secured through the obstetrician.

The county medical society is furnished with a copy of all the Rh negative results with name and address of the patient. This is done with a thought to forming a County Rh negative Donor's Club. The members of the Passaic County Medical Society are said to be well satisfied with the results of this experiment and apparently wish it continued.

## Oregon Telephone Employees Heave A Weighted Club

Oregon telephone employees, according to *Northwest Medicine*, through the medium of their recently incorporated Telephone Employees Hospital Association, without waiting for a reply from the State Medical Society Council, have demanded cut rate medical care on a prepaid basis. The plan does not appear to have originated in any reputable medical group or circles and the initial contact with the medical society was so late as to appear virtually an afterthought. By demanding a rate of $1.75 to $2 including drugs the telephone employees shut their eyes to all actuarial experience. This is a definite crisis in the affairs of Oregon's doctors, we are told, a bold attempt to foist cut rate medical care upon them and their patients under the guise of a poorly conceived medical plan.

## New Treatment for Lymphogranuloma

Because of military demands for a drug to combat kala-azar, a fatal infectious disease sometimes called "black fever," and lymphogranuloma, a venereal disease, also known as "tropical bubo," the Winthrop Chemical Company, Inc., has recovered the secret of Neostibosan, and is now producing this former German compound from all-American intermediaries, according to an announcement recently by Dr. Theodore G. Klumpp, president.

The drug is described as "an extremely complex ethylstibamine pentavalent antimony compound," and, while it has been in use in tropical medicine since 1927, has never before been made in this country. Dr. A. E. Scherndal, vice-president of Winthrop at the Rensselaer plant, was given the neostibosan problem about two years ago. Only a description of the drug, not a complete formula, was in the possession of laboratory workers, who, commencing in May 1942, "unravelled the mystery" within a year's time, enabling the company to consider manufacture of the compound on a reasonable scale last year. At present, demands of the armed forces are being met, according to Dr. Klumpp, and experiments have started to determine whether the drug has other uses.

Sodium antimony in the treatment of kala-azar was first used as early as 1914 by Sir Leonard Rogers. Then the Germans developed what they called stibosan, following with neostibosan in 1927. Until entry of the United States in the present war with dispersal of troops and naval personnel to distant tropical bases, there was no need for the drug in this country, Dr. Klumpp pointed out.

Kala-azar seems to be transmitted to man by the bite of the desert sandfly, perhaps by the bedbug in India, and also by a mosquito known as the "anopheles puntipenis." The disease occurs along the Mediterranean shore in West Africa, Mesopotamia, southern Russia, India, North China, and Brazil. It is marked by fever, progressive anemia, wasting, enlargement of the spleen and liver and dropsy.

According to military authorities, there has been a marked increase of lymphogranuloma, for which the drug is also indicated. While commonest in the tropics, the malady is also found in this country. It chiefly affects the lymphatic tissue of the iliac and the groin. The virus causing it has not been isolated.

## Compulsory Sickness Insurance in Great Britain

Physicians in Great Britain are disturbed over several proposals relating to government service. *British Medical Journal* (February 10) calls attention of proposal by Mr. Willink, Minister of Health, to subsidize medical schools provided they will take in more women and provided government can influence the curriculum. The title of the editorial, "Power Through Purse," indicates medical attitude. British Information Services, issuing bulletin in the United States, March 1945, make propaganda for compulsory sickness insurance. One page says "Family doctors for all, with their bills paid in advance, is the central idea of Britain's post war National Medical Service. . . . Under the new plan—which has already been acepted in principle and for which legislative details are now being worked out—every man, woman and child will have compulsory health insurance. It will pay for a general practitioner of the patient's own choosing, a specialist when needed, and all necessary medicines, hospital service and home nursing; but there will be no interference with the patient's right to choose and pay for a doctor outside the system if he wishes. Thus the plan is an ingenious combination of the security against financial hardship as a result of sickness, offered by 'socialized' medicine, with the freedom of choice and encouragement of skill, offered by private medical practice. Workers, employers, and the State will share the cost—which it is estimated will amount to some $600,000,000 a year compared with the $250,000,000 spent under the present National Health Insurance Plan."

Such propaganda generalizations need to be supported by evidence. Actually thus far nothing has been made effective. The British propaganda booklet reports all sorts of welfare proposals as if they were already effective.

Robert J. Watt, International Representative of the American Federation of Labor, returning from Great Britain writes in the *American Federationist* for March 1945 that he found, much to his surprise, no great enthusiasm for social security on Beveridge lines. "With prices as they are at the present time," he said, "the projected rates of benefits, to those I talked with, represent a very low level of subsistance. The cost of around a dollar off the week's wages sounded disproportionately high to the same people."

## Getting Patients Out of Bed Early in the Puerperium

The following letter is reprinted from the *Journal of the American Medical Association*, and makes a fitting complement to an editorial appearing in the CONNECTICUT STATE MEDICAL JOURNAL, September 1944, page 618, entitled "Streamlining in Obstetrics."

To the Editor:

On page 839 of *The Journal* of July 22 Dr. Morris L. Rotstein of Baltimore makes the statement that during the blitz of 1940-1941 London maternity patients delivered in hospitals were allowed up a day after labor and sent home on the second or third day post partum. He adds that "no ill effects resulted from this mode of treatment."

It would seem that Dr. Rotstein is under some misunderstanding, for although one half of the institutional confinements in London take place in hospitals directly under my control and I am in close touch with the voluntary hospitals responsible for the remaining institutional births in London, I have never heard of such a routine. The true facts may interest your readers. During the whole war period, all expectant mothers who could be persuaded to leave London were evacuated at the eighth month to country maternity homes organized by the Ministry of Health and there they were retained until the usual fourteen days after confinement. At the end of this period they were discharged to country billets with their infants, but many returned soon after to their homes in London, especially if the blitz was not active.

Of the mothers who could not be persuaded to leave London, those who were normal medically and whose homes were suited for confinements were expected to have their babies at home. This is the usual prewar custom in England, and we did not depart from it during the blitz, but of course enemy action rendered many houses unsuitable and added to the pressure on our beds. Further, all hospitals retained the fourteen day period during the early part of the war, but many (including the London County Council's hospitals) were obliged to reduce the mothers' stay to ten or twelve days as accommodation was reduced by bombing or by necessary air raid precautions. Any woman who had to be sent home earlier (which very rarely happened and never before the seventh day) was conveyed by ambulance and a visiting nurse was sent to care for her. It is also true that in two areas of London where hospital accommodation became very short the women were (and are still) transferred by ambulance to a suburban hospital with excellent accommodation on the fourth day, but they are not expected to go home till the twelfth day. No bad effects have been reported, but the arrangement is much disliked by the women and will be abandoned directly events permit. It is probably a garbled version of this plan which has reached Dr. Rotstein.

May I add that we have had many attempts in the last forty years to introduce a shortened puerperium into English midwifery practice but they have never taken hold. The present tendency is to insist more firmly than ever on six to seven days in bed and a total fourteen days of rest and exemption from household duties, with a longer convalescence still after complicated confinements. The value of graduated physical exercises during the antepartum period and from the third or fourth day of the puerperium is of course widely appreciated.

Allen Daley, M.D.
Medical Officer of Health,
London County Council.

## New Dean at Western Reserve

Dr. Joseph Treloar Wearn, professor of medicine at Western Reserve University, has been appointed dean of the University's School of Medicine.

Appointment to the post, considered one of the most important positions in the field of medical education in the United States, was announced recently by President Winfred G. Leutner of Western Reserve, who said Dr. Wearn will take his new position about April 1. The 101-year-old School of Medicine at Cleveland, Ohio, ranks among the first ten scholastically among the institutions of its kind in the United States.

Dr. Wearn succeeds Dr. Torald H. Sollmann, who retired as dean last July 1, after nearly 50 years of service with the University.

The new dean of the School of Medicine will continue as professor of medicine at the University and as director of the department of medicine at Lakeside Hospital.

He is widely known as a teacher in his field and for his research in medicine. His chief research work has been in physiology of heart disease, and in the diseases of the blood.

# SPECIAL NOTICES

## POSTGRADUATE COURSE IN CARDIOLOGY FOR SUMMER 1945

**Offered at Montefiore Hospital, Gun Hill Road, Bronx, N. Y.**

In affiliation with Columbia University

**June 5 to August 14, 1945**

10 A. M.—12 M. TUESDAY

Elementary Cardiology—Fee $35

Drs. Abraham Jezer, E. Goldberger, Harry Gross, Joseph Ballinger and others.

The purpose of this course is to give the general practitioner an introduction to the methods of diagnosis and treatment of heart disease. Chief emphasis will be placed on bedside teaching and demonstration of cases to small groups of students. The course will include demonstration of cardiac fluoroscopy, of measurements of venous pressure and circulation times; discussions on criteria of classification, on correlations with pathology and on principles of treatment. This course may be taken simultaneously with Elementary Electrocardiography and Elementary Cardiovascular Roentgenology.

It is a prerequisite to all subsequent courses in the integrated cardiology program. For further information, address The Dean, Faculty of Medicine, Columbia University, 630 West 168th Street, New York 32, New York.

## CHEST PHYSICIANS NEXT EXAMINATION

The Board of Examiners of the American College of Chest Physicians announce that the next written examination for Fellowship will be held at Chicago, June 16. Candidates for Fellowship in the College who plan on taking the examination should contact the Executive Secretary of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

# OUR NEIGHBORS

## Maine

The Maine Medical Association in common with nearly all the other state societies has cancelled its 1945 annual meeting in compliance with a request from the Office of Defense Transportation. This meeting was to have been held at the Poland Spring House, June 24 to 26, inclusive.

## Massachusetts

The Blue Shield reports that it has added more new members in the past six months than it acquired in the first eighteen months of business. With nearly 125,000 members and 4,000 participating physicians, it believes that it has established itself as a definite part of the medicoeconomic structure. An average of about five physicians are becoming participants, every working day.

## New York

The Medical Society of the County of New York has announced a new service for discharged medical veterans known as Veteran's Service. This new service will aid the discharged medical officer to find office space, residential accommodations, part or full time employment in governmental or private service, office furniture or scientific equipment, opportunities for postgraduate instruction, or whatever else needed to reestablish home and practice.

The two bills passed by the New York legislature to permit the granting of a medical license to graduates of any medical school in the United States have been vetoed by Governor Dewey. The Governor deserves the congratulations of the entire medical profession for his appreciation of the need for the maintenance of high standards of medical education and medical care.

Both the 1945 Annual Meeting and the House of Delegates Meeting of The Medical Society of the State of New York have been cancelled in compliance with the request of O.D.T.

*The New York State Journal of Medicine* reports a surplus over all expenses for 1944 of $30,252.29. This is an increase of almost $24,000 over 1943 and is accredited to war boom prosperity and increased efficiency in the business department.

At a meeting of the Council of The Medical Society of the State of New York on January 11, Dr. George W. Kosmak was appointed managing editor of the Society *Journal*. Dr. Robert R. Hannon has been appointed to the position of executive officer of the Society, succeeding Dr. Joseph S. Lawrence now in the Washington office of the American Medical Association.

The Public Relations Committee of the Medical Society of the County of New York has developed a plan to increase the number of opportunities for returning medical veterans in the fields of medical

# To those who wonder why we need still bigger War Loans

IN THE 7th War Loan, you're being asked to lend 7 billion dollars—4 billion in E Bonds alone.

That's the biggest quota for individuals to date.

Maybe you've wondered why, when we've apparently got the Nazis pretty well cleaned up, Uncle Sam asks you to lend more money than ever before.

If you have, here are some of the answers:

### This war isn't getting any cheaper

No matter what happens to Germany—or when—the cost of the war won't decrease this year.

We're building up a whole new air force of jet-propelled planes and bigger bombers.

We're now building—even with announced reductions—enough new ships to make a fair-sized navy.

At the time this is written, our casualties are nearing the million mark in dead, missing, and wounded. Wounded men are arriving in this country at the rate of over 30,000 a month. The cost of caring for these men at the battle fronts, transporting them home, and rehabilitating them when they get here, is mounting daily.

No—this war isn't getting any cheaper. And won't for some time.

### This year—2 instead of 3

We need as much War Bond money this year as we did last. But there will be only 2 War Loans this year—instead of the 3 we had in 1944.

Each of us, therefore, must lend as much in two chunks this year as we did last year in three. That's another reason why your quota in the 7th is bigger than before.

The 7th War Loan is a challenge to every American. The goal for individuals is the highest for any war loan to date. The same goes for the E Bond goal. Find your personal quota—and make it!



THE MIGHTY 7th WAR LOAN

ALL OUT FOR
THE MIGHTY 7th WAR LOAN

research and teaching. Each medical school and hospital in the county in which research and teaching activities, or either of them, is carried on has been asked to appoint a committee on expansion of research and teaching activities within its own institution and to designate a representative member of that committee to sit as a member of a council of medical schools and hospitals. The purposes of the council will be to stimulate the individual institutions to carry out this program, to provide for an exchange of information and coordination of activities as between the individual institutions and perhaps, in some instances, to act or speak in the combined interest of all these institutions in making contact with some of the larger sources of funds which might support these activities.

### Rhode Island

The Committee on University, Hospital, and Medical Society Relations of the Rhode Island Medical Society has suggested the establishment of a central Institute of Pathology to serve many or all of the hospitals of the State. The committee believes that all hospitals, in particular the smaller ones, as well as all hospital staffs and their patients would profit from such an arrangement. It has also been suggested that such an institute might furnish laboratory service to individual physicians. As a part of this new organization a system of residency in pathology is proposed, whereby young physicians might be prepared for National Board certification.

## NEWS
## *from County Associations*

### Fairfield

The regular monthly meeting of the Bridgeport Medical Society was held at the University Club in Bridgeport on Tuesday, May 1. The speaker was J. Stanley Kenney of New York City and his subject "Recognition and Treatment of the Primary Atypical Pneumonias."

Joseph C. Quatrano of 893 Clinton Avenue, Bridgeport, has resumed his practice at the above address. He has been serving with the Medical Corps of the United States Navy for the past two years and recently received an honorable discharge.

### Hartford

Martin I. Hall, medical director, New Departure Division, General Motors Corporation, Bristol, is quoted in *Industrial Medicine* for January 1945 when he expressed the opinion that the plant physician can function best if he is regarded as the health officer of the plant, responsible for plant hygiene. Dr. Hall was one of the speakers at the Industrial Health and Safety Conference in New Haven.

James H. Biram, medical director, Colt's Patent Fire Arms Mfg. Company, Hartford, together with H. P. Quadland of the Safety Research Institute is the author of "An Industrial Physician Looks at the Flammable Solvents," published in *Industrial Medicine*, January 1945.

The Hartford Board of Health reports the following comparative figures for 1943 and 1944 as applied to that city:

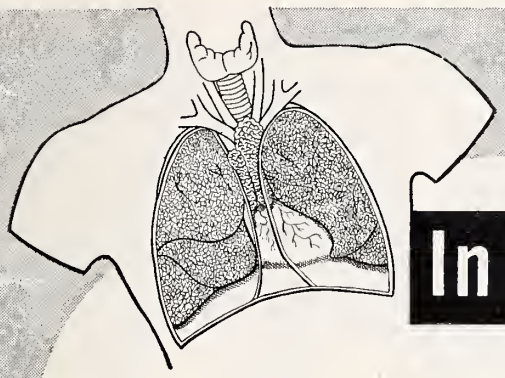
| | 1943 | 1944 |
|---|---|---|
| Population | 185,850 | 182,000 |
| Crude Death Rate | — | 10.0/1000 |
| Birth Rate | 20.7/1000 | 18.0/1000 |
| Maternal Death Rate | 1.8 per 1000 children born | 1.5 per 1,000 children born |
| Death by Accidents | 51.1/1000 | 81.3/1000 |

Captain William Beecher Scoville, AUS, of Hartford is co-author with Captain James C. White, USNR, of "Trench Foot and Immersion Foot" published in *The New England Journal of Medicine* April 12, 1945).

George A. Wulp of Hartford has been sent by the War Department to Germany as a civilian physician assigned to special duty.

Charles W. Goff of Hartford recently published results of a study in which eighty-three procedures were presented using os purum as a substitute for the autogenous implant. This study appeared in the October issue of *The Journal of Bone and Joint Surgery*, 1944.

Commander E. H. Crosby, MC–USNR, chief orthopedist, Navy Hospital, Camp LeJeune, North Carolina, recently entertained a Hartford orthopedic surgeon who visited him at Camp LeJeune and demonstrated a new procedure which Dr. Crosby has developed for the prevention of habitual dislocations of the shoulder. Dr. Crosby has developed a most ingenious method in which he uses the biceps tendon to suspend the humerus from the acromial process. This work in all probability will soon be published. Dr. Crosby has an exceedingly active



# In the Pneumonias

DURING the recent past, numerous investigations have shown that penicillin is the treatment of choice in the pneumonias (pneumococcic, streptococcic, staphylococcic).* Penicillin is virtually nontoxic, even in the massive dosages at times required. Its efficacy apparently is the same against sulfonamide-resistant and nonresistant organisms of the groups named. Even in advanced stages of the disease, in the presence of serious complications, penicillin usually proves a life-saving measure.

Since penicillin has become available in quantities that may well be adequate for all needs, it merits being the physician's first thought with every pneumonia patient.

*Stainsby, W. J.; Foss, H. L., and Drumheller, J. F.: Clinical Experiences with Penicillin, Pennsylvania M. J. 48:119 (Nov.) 1944.

McBryde, A.: Hemolytic Staphylococcus Pneumonia in Early Infancy; Response to Penicillin Therapy, Am. J. Dis. Child. 68:271 (Oct.) 1944.

Stainsby, W. J., Chairman, Commission for the Study of Pneumonia Control of the Medical Society of the State of Pennsylvania: Up-to-Date Facts on Pneumonia, Pennsylvania M. J. 48:266 (Dec.) 1944.

Larsen, N. P.: Observations with Penicillin, Hawaii M. J. 3:272 (July-Aug.) 1944.

## PENICILLIN-C.S.C.

Penicillin-C.S.C. deserves the physician's preference not only in the pneumonias, but whenever penicillin therapy is indicated. Rigid laboratory control in its manufacture, and bacteriologic and biologic assays, safeguard its potency, sterility, nontoxicity, and freedom from pyrogens. The state of purification reached in Penicillin-C.S.C. is indicated by the notably small amount of substance required to present 100,000 Oxford Units. Because of this purity, incidence of the undesirable reactions, attributed by many investigators to inadequate purification, is greatly reduced.

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Penicillin-C.S.C. stands accepted by the Council on Pharmacy and Chemistry of the American Medical Association.



orthopedic service and is said to be making a fine record at Camp LeJeune.

## Litchfield

Major Royal Meyers of Watertown, a member of the staff of the Waterbury Hospital, is home from South Africa. He will be stationed at Palm Beach, Florida, after a 21-day leave.

The Litchfield County Medical Association was guest of the Litchfield County Hospital, Winsted, for its annual spring meeting on Tuesday, April 24.

Following a very delicious steak dinner, the business meeting was called to order by the president, Arthur H. Jackson of Washington, and there followed the usual routine. H. Gildersleeve Jarvis, president of the State Medical Society, spoke briefly, stating that the state medical meeting has been cancelled for this year due to transportation difficulties. He spoke also of prepaid medical care, and the progress of the committee in charge of the permanent offices for the Society. James Raglan Miller, chairman of the Council, gave a brief report, as did Creighton Barker, secretary of the Society.

The association voted its approval of the formation of a Woman's Auxiliary; and discussed at some length a suitable memorial to Frank H. Reichenbach, who was Litchfield County's first actual battle casualty.

The following officers were elected for the coming year: President, Donald W. Herman, Winsted; Vice-President, W. Bradford Walker, Cornwall; Secretary, Thomas J. Danaher, Torrington. State delegates: T. J. Danaher, Torrington; M. J. Reidy, Winsted; H. W. Markwald, New Hartford.

The president's address, delivered by Dr. Jackson, had as its title "Electric Shock Therapy: Its Use In a General Hospital." Dr. Miller gave a paper on "Office Gynecological Procedures," which was also greatly enjoyed.

## New Haven

The New Haven Department of Health reports a new record with but one case of typhoid fever during the past year. 1944 was the 14th recent year without a scarlet fever death and the 11th consecutive year without a diphtheria death for the department. There were also no deaths from common communicable diseases.

L. H. Nahum of New Haven is the author (with H. E. Hoff) of "The Localization of Ventricular Extrasystoles" published in *The Yale Journal of Biology and Medicine*, March 1945. In the same issue may be found "Health Services For Hospital Personnel: II. Purposes, Scope, and Philosophy," by Arthur J. Geiger of New Haven. Dr. Geiger's paper was presented in part before the First Institute on Personal Management of the American Hospital Association held at New Haven, June 30, 1944.

Francis G. Blake of New Haven delivered the Charles V. Chapin Oration at the 134th annual meeting of the Rhode Island Medical Society on May 16. His subject was "Some Recent Advances in the Control of Infectious Diseases." Arthur J. Geiger of New Haven presented a paper on "The Treatment of Acute Coronary Thrombosis" before the same gathering on May 17.

Lieut. Elliot Mayo is spending a furlough in Waterbury after service in the Marine Corps in the United States. He is a member of the staff of the Waterbury Hospital.

The 161st Annual Meeting was held on Thursday, April 26, at the New Haven Medical Association Building. The following applicants for membership were approved and elected:

| | | |
|---|---|---|
| John Brody | New Haven | Tufts, 1939 |
| Marion R. S. Brown | Meriden | Temple, 1943 |
| Joseph H. Evans | New Haven | Boston, 1902 |
| William J. Lenkowski | Waterbury | New York, 1937 |
| Frank J. Lepreau, Jr. | New Haven | Harvard, 1938 |
| Kenneth R. Morgan | New Haven | Yale, 1942 |
| William J. McNamara | New Haven | Vermont, 1929 |
| Hoyt C. Taylor | New Haven | Cornell, 1938 |
| Maurice Tulin | New Haven | Yale, 1942 |
| Herbert T. Wagner, Jr. | Meriden | Indiana, 1936 |
| Johanna Waldemar-Kertesz | New Haven | Vienna, 1926 |

The following members were elected to office: President, Ralph W. Nichols; Vice-President, M. Heminway Merriman; Clerk, Ralph E. McDonnell; and a member of the Executive Committee to succeed William J. H. Fischer, Andrew J. Jackson.

## New London

Frank Leslie joined the staff of the Norwich State Hospital on April 14, 1945, as senior physician (psychiatric), on a durational appointment. Dr. Leslie was graduated from Winthrop (N. Y.) Academy, later he attended Massachusetts College of Pharmacy and graduated from Medical Department, Bowdoin College, Brunswick, Maine.

His postgraduate work was carried out at St. Elizabeth's Hospital for the Insane, Washington, D. C., and U. S. Veterans' Administration Post



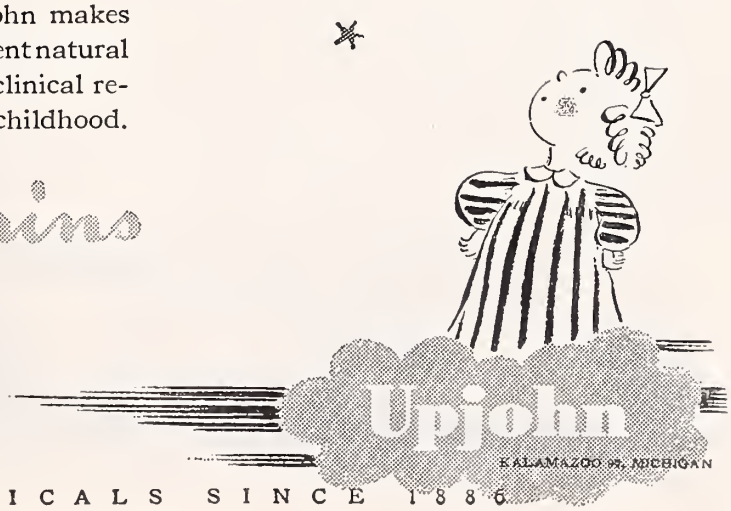
# By the light of the moon

Might as well expect the average child to get adequate vitamin D "by the light of the moon" as to depend wholly on the sun. Even in the summertime when the sun is shining many children are not as exposed to it as we might think. Cloud filtration and the uncertainty of adequate exposure even in such sunny areas as California[1] have led leading nutritionists to the conclusion that supplementation with vitamin D is essential. Essential as long as growth persists—through infancy, childhood and adolescence.

Regardless of season or geography, Upjohn makes available convenient, palatable, highly potent natural vitamin preparations to meet the varied clinical requirements of earliest infancy through late childhood.

Upjohn Vitamins

1. Am. J. Dis. Child. **54**: 1227, 1937.




FINE PHARMACEUTICALS SINCE 1886

Graduate School in New York City. He was commissioned in Medical Corps, U. S. Army, July 14, 1917, and as senior surgeon in U. S. Public Health Service in 1920. From 1917 to 1943 he served in Federal mental hospitals, retiring in 1943.

Dr. Leslie is a member of the American Medical Association, the American Psychiatric Association, the Association of Military Surgeons, the Louis T. Batty Post No. 4, American Legion, Augusta, Georgia, the Military Order of the World Wars, Washington, D. C., and is a diplomate of the American Board of Psychiatry. He was commissioned as Lieutenant Colonel, Medical Reserve Corps., U. S. Army, at Fort Custer, Michigan, in 1924.

## Tolland

The annual meeting of the Tolland County Medical Association was held at the Olde Homestead Inn, Somers, on the evening of April 17. The usual conviviality reigned under the aegis of Roy Ferguson. Following dinner there were informal addresses by Col. William D. Smith, who expressed the appreciation of the Army toward those who gave their time to the selective service, etc.; J. R. Miller, for the Council, mentioned the building fund, Woman's Auxiliary, and various legislative problems; H. Gildersleeve Jarvis gave a salutation as president of the State Society. It was a pleasure to have Millard Knowlton, Friend Lee Mickel, Dr. Brown and others of the State Department of Health with us, as well as the perennials, "Dick" Wiedman and Arthur Emmett. The speaker of the evening was Ralph Kendall, who elucidated the subject of blood transfusions and the Rh factor. His dissertation fell on receptive ground and was received with acclaim.

At the following business meeting, Leonard Levine of Ellington was elevated to the presidency, and Charles T. LaMoure, the vice-presidency.

Word from Francis Burke and William Schneider reports them busy in the Philippines. Schools, churches or bamboo huts are converted into operating rooms and wards until casualties can be moved to base hospitals. The only natives treated are battle casualties. Leafy vegetables are eschewed instead of chewed because of prevalent parasitic diseases.

# NEW BOOKS IN REVIEW

*THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK, SOCIOLOGICAL, MEDICAL, PSYCHOLOGICAL AND PHARMACOLOGICAL STUDIES BY THE MAYOR'S COMMITTEE ON MARIHUANA. Lancaster, Pa.: Jacques Cattel Press.* 220 pp. $2.50.

Reviewed by MILLARD KNOWLTON

This book is beautifully printed in readable type and makes an attractive volume. The studies appear to have been meticulously made and carefully recorded. The difficulty appears to be that the observations made in this study do not justify some of the conclusions reported. This is very properly emphasized in an editorial printed in the *Journal of the American Medical Association* for April 28, 1945.

Some of the shortcomings of the report may be mentioned as follows:

(1) The report is based on experiments with 77 prisoners who were in confinement during the period of study. Quite obviously, this is too small a number to justify general conclusions, even though they had been selected at random instead of being selected from prisoners.

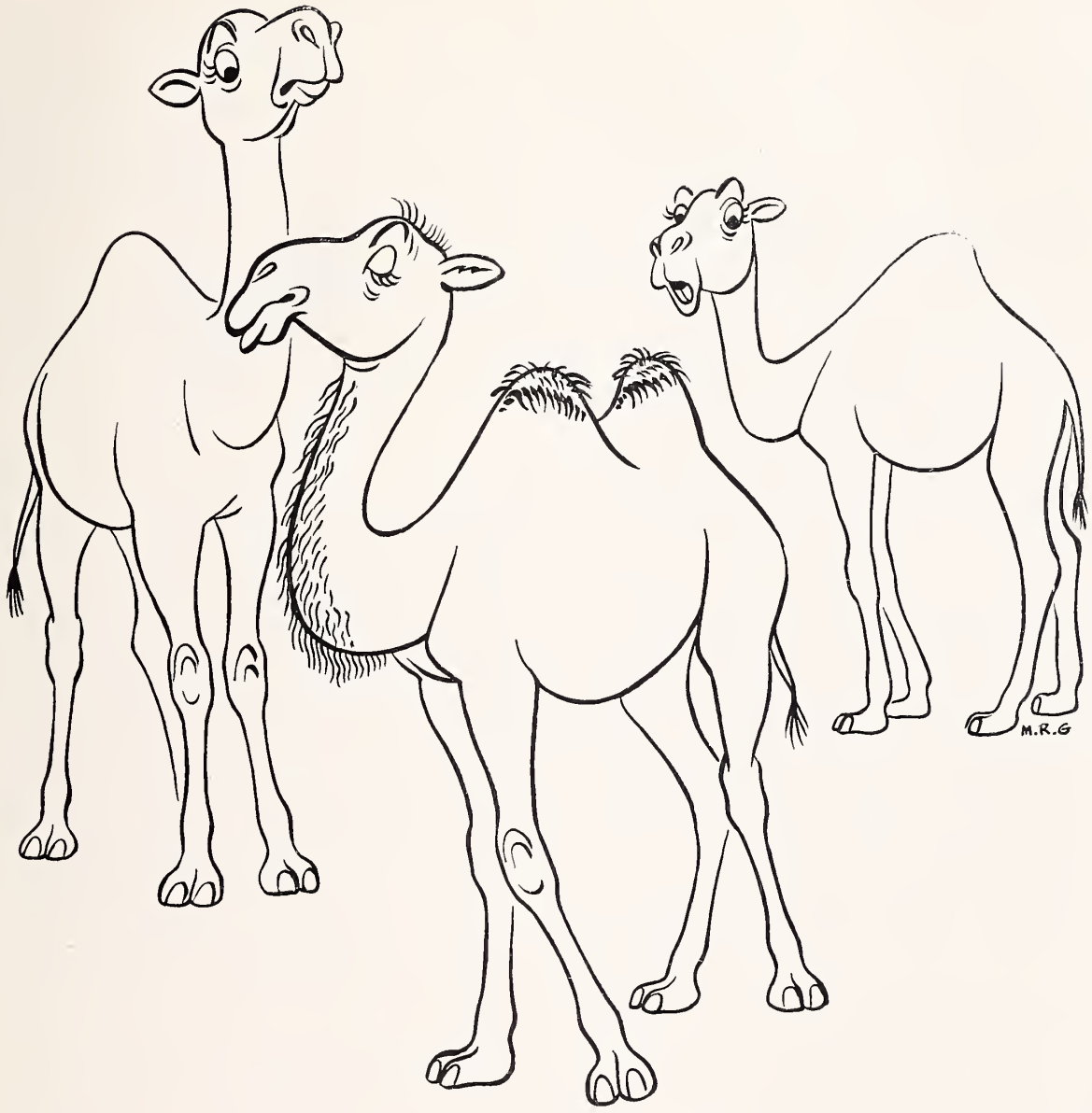
(2) They were observed in groups of 6 to 10 over a period of from 4 to 6 weeks. Quite obviously, observation for so short a period does not justify conclusions concerning the effects of the drug when used over a period of years. Thus, the conclusion that "indulgence in marihuana does not appear to result in mental deterioration" has no justification by the results of the study reported.

(3) Observations on the effect of predetermined dosage on incarcerated people where the dose was not allowed to go beyond "the pleasurable principle" do not justify conclusions as to the effects of marihuana on people who do not have such limitation on dosage. Thus, it would appear that the observations made in this study would not justify any conclusion with reference to the effect of long time use of the drug by people who are free to select their own dose.

(4) A wide variation in potency of hemp from different parts of the world is recognized in the statement that "Tunisian hemp is still 4, 6 and 8.7 times as potent as a Wisconsin. a Kentucky, and a Manchurian hemp, respectively." Quite obviously, the effects resulting from the use of hemp of one potency would not justify conclusions concerning the use of hemp of a much higher potency.

Some of the observations made in this study were incorporated in a paper read at the American Psychiatric Association Meeting in Boston in May, 1942 and published in the American Journal of Psychiatry for September, 1942. As a result of this publication, two significant letters were sent






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Nicotinamide ..... *40 Milligrams*
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## Maltine with Vitamin Concentrates

to the editor of the *Journal of the American Medical Association*, one by H. J. Anslinger, commission or narcotics at Washington, D. C., which was published in the JOURNAL for January 16, 1943, and the other by Doctor J. Bouquet of Hospital Sadiki in Tunis which was published in the JOURNAL for April 1, 1944. Doctor Bouquet is looked upon as the world's outstanding authority on marihuana, and Mr. Anslinger is regarded as our outstanding authority on the narcotic problem in this country. The two letters from these outstanding authorities give very considered and conservative views of the problem. Yet, in spite of the publication of these letters, the book was published later giving unwarranted conclusions.

The insistence of those who wrote the book in giving unwarranted conclusions, in spite of convincing evidence to the contrary, may remind one of the persistence of a narcotic addict in explaining to a physician the reason why a narcotic is needed to alleviate symptoms. For example, one addict in Connecticut had a habit of putting on a heavy brace around her neck when going to a doctor's office for prescriptions to convince the doctor that she actually had need for narcotics. After getting the prescription, she would leave the doctor's office, take off the brace and go her way. Another addict acquired the ability to raise her rectal temperature from 5 to 6 degrees by exercising the muscles about the anus. Strangely enough, the report carries the suggestion that Cannabis may be used in the treatment of addiction to other narcotics. This may well accord with the psychology of a drug addict who finds it difficult to get the drug he desires and who wishes to escape the pains of withdrawal by changing to another narcotic. According to recognized authorities, such a change can only result in the substitution of one addiction for another.

As an example of confused thinking in the report may be mentioned the following: "The numerous preparations having marihuana activity are all obtained from members of the Cannabinaceae family. These are usually distinguished from the common hemp by differences in their geographical origin." The fact of the matter is that there is only one species of hemp known as "Cannabis sativa." Many names are applied to this species in different parts of the world, but they are all the same species in botanical classification rather than different "members" of the "family." This may be a reminder of the short-sighted man who "could not see the forest for the trees."

No doubt many of the observations made in the study are accurately recorded. Yet, in spite of the recording of occasional psychotic episodes following the small dosage given in the study, an attempt appears to be made to draw up conclusions without giving consideration to such symptoms as excitement, antagonism, anxiety, and erotism reported to result from the limited dosage given in the experiment. It is recognized that the harmful effects of Cannabis or marihuana may have been exaggerated for publicity purposes in popular writing, but this does not justify swinging the pendulum entirely over to the opposite side rather than taking a middle course that duly recognizes actual dangers. The numerous crimes reported to have been committed while under the influence of marihuana cannot be dismissed with a gesture. Recognized authorities are fully aware that such incidents have occurred.

On the whole, many interesting observations appear to have been made during the study, but the conclusions drawn are not justified. Incidentally, the cigarette pictured on the paper cover of the book has all the appearances of a machine-made cigarette instead of a hand-made cigarette where marihuana is used. The conclusions drawn from the study may have a similar misleading effect. Unfortunately, evidences are beginning to accumulate as to the bad effects of the report on law enforcement as emphasized in the editorial mentioned in the foregoing.

*OPERATIONS OF GENERAL SURGERY. By Thomas G. Orr*, M.D., Professor of Surgery, University of Kansas School of Medicine, Kansas City, Kansas. *Philadelphia: W. B. Saunders Company.* 1944. 723 pp. $10.00.

Reviewed by LEWIS C. FOSTER

This book is dedicated to the art of surgery. Any experienced surgeon realizes that this art must be acquired and perfected by actual practice in the operating theater. A sound theoretical background and a clear mental picture of techniques to be followed are a necessary prerequisite, however, and this book is an excellent aid in achieving this end. This kind of a book should teach the surgeon first of all how to make and how to repair a wound. These elemental but fundamental factors are often forgotten in multitudinous discussions of vitamins in wound healing, edema from hypoproteinemia, etc., etc. Dr. Halsted taught, and most surgeons have forgotten, the importance of gentleness in handling living tissue, meticulous hemastasis, and accurate approximation. He taught, and one should remember, that tissue will be strangulated by tight ligatures, that small sutures and small bites of tissue leave less foreign material in the wound. A textbook devoted to the art of surgery should offer an unbiased estimate of the value and use of various suture materials. If a student is taught these things thoroughly, he can go far in all types of major operative techniques.

A critical analysis of this book reveals defects. There are, as there must be in every book, omissions. Since technical details have been emphasized in this review, there is no mention of the suction apparatus, a useful adjunct for the general surgeon as well as for the neurological surgeon. There is no discussion of the primary anastomosis of the oesophagus in congenital atresia and oesophageal tracheal fistula, so brilliantly performed by Haight, Ladd, and others. There is no discussion of ligation of the proximal veins in thrombophlebitis and one is left with the impression that paravertebral injection is the only method of treatment.

The gastric surgeon might not agree with many opinions expressed in the section on gastric surgery. The preliminary discussion, so interesting and sound in most sections, doesn't coincide with many surgical opinions. For example, a gastroenterostomy is offered as the treatment of pyloric obstruction. The indications for doing a subtotal gastrectomy are large benign tumors, sarcomas, carcinoma of the stomach, and large and perforating gastric ulcers. There is no mention of surgery in the treatment of greater curvature ulcers, or of duodenal ulcers with the complication of massive hemorrhage, etc.

These criticisms are submerged and completely over-



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For nearly two decades at the annual dinner of the Connecticut State Medical Society it was the custom for Colonel Osborn to address the Society under the title, on the elaborate menu, of "Our Friend—The Press." The greatly anticipated speech was delivered at the end of the dinner. Year after year in his amiable, urbane manner he dispensed his rich humor to the doctors assembled and he fostered most friendly relations between the Press and the Medical Profession in Connecticut.

Colonel Osborn distinguished himself as a newspaper editor. He served his community with a devotion that brought him great distinction—the kind that goes with true greatness of character. His editorial pen was unique, facile and respected. It was a powerful influence for good.

It has been the practice of this organization to appraise this business of supplying the needs of the medical profession as a SERVICE. The community we serve is the State of Connecticut. It is pleasant in this our eightieth year to recall many incidents of historical interest. They have all been in some way a part of our development. Whatever your problem, when you telephone New Haven 5-3165 you will find us ready to serve.

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In every neighborhood there walks among the people, a man who has devoted his life to the care of the sick. The unswerving devotion and the skills a physician brings to the sick room and to the operating table are distinctly his own.

We have walked beside that man for eighty years, alert and prompt to place in his hands and to surround him with all he needs to do his work.

Our part has been a comparatively prosaic one but in retrospect, the foresighted policy of our founder, Dr. E. L. Washburn, has shown many visible results. We have been keenly aware of the strides of progress and have seen the fruits of achievement. The importance of dependable service becomes more and more significant. We keep our eyes on the new horizon.

Frank McDonnell

*President*

## THIS IS NEWS - - -

When we announce that arrangements have been completed with The Ohio Chemical and Manufacturing Company to be distributors for Continental Parenteral Solutions in Connecticut, you may know it has been done after much deliberation. One of the most important reasons why we are glad to make this announcement is because of the Continental "Closed Technique." This A.M.A. accepted parenteral solution is administered without breaking the sterile seal of the flask. This is done simply by inserting the sterile flask needle through the stopper diaphragm. The service to users of Continental Parenteral Solutions has been perfected to make administration a quick and positively sterile procedure.

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shadowed by the merits of this book. It offers the sound advice of an excellent and experienced surgeon. It has an unusual number of excellent illustrations and a comprehensive bibliography. It is a wholesome, exhaustive, and lucid contribution to the art and craft of surgery. The medical student will find it a useful and handy book in clarifying the methodology of surgery. The young surgeon will find it a faithful friend, and even the general practitioner will find it handy to check up his surgeon.

The pictures alone are worth the price of the book.

*MEDICAL GYNECOLOGY. By James C. Janney*, M.D., F.A.C.S., Assistant Professor of Gynecology, Boston University School of Medicine. *Philadelphia: W. B. Saunders Company.* 1945. 389 pp. $5.00.

Reviewed by Stanley B. Weld

The publications in the field of obstetrics and gynecology of recent years have tended to emphasize more and more the clinical picture as presented by the individual, rather than the disease pattern into which a patient should be fitted. Dr. Janney stresses the patient's complaints, believing that by so doing a more correct diagnosis is not only reached, but also a more physiologic program of treatment attained. As in other texts on medical gynecology, this volume presents the writer's own experiences, methods and opinions.

Each chapter of the section dealing with complaints affords a list of physiologic causes and pathologic causes. Blocked off to catch the eye there may be found in each chapter of this section also an outline of the procedure to be followed in establishing a diagnosis. Another section of the book deals with physical findings and still another with gynecologic treatments. There is some overlapping and repetition in these three sections but this seems unavoidable. Special tests and examinations have been grouped together. This is a handy arrangement.

The outstanding contribution made by the author is the section on socio-medical problems. Here the whole gamut of premarital and marital problems is presented in a very practical manner. Every physician might well profit by reading the chapters in this section.

There are many niceties of office practice afforded the reader as this book ostensibly limits itself to office gynecology. In discussing treatment, however, it enters the realm of hospital practice with such subjects as anesthesia, including caudal, and operations for prolapse. No mention is made in this latter discussion of one of the simplest, the LeFort Operation. The author's extensive use of the hormones is stimulating because of the sound reasoning behind it. Note is taken of his reference to James R. Miller's use of testosterone in endometriosis as a preoperative measure. One gets the impression that retroversion and retroflexion are synonymous, which certainly is not the truth outside of Boston. The preference for the swab instead of the wire loop in obtaining urethral and cervical smears, the castigation of the vinegar douche as a fad, and the statement that post operative radiation in malignant disease is "favored by most doctors" may raise some questions in the reader's mind. In spite of these minor shortcomings, Dr. Janney deserves the appreciation of his fellow gynecologists for a contribution which is so arranged as to make its contents readily accessible as a reference for the busy general practitioner, as well as a reliable guide for the medical student.

*FORGET YOUR AGE! By Peter J. Steincrohn*, M.D. *New York: Doubleday, Doran & Co.* 1945. 238 pp. $2.50.

Reviewed by Stanley B. Weld

"Learn to grow old so gracefully that Time forgets to mark you." What a necessary reminder in this day of war, of long hours of work, and of anxiety and worry! There must come days of inventory in every individual's life, otherwise the mad rush of the world becomes engulfing and a last minute attempt to stem the tide, useless. The author in a conversational manner recounts the points to be listed in such an inventory and lists them from the physician's as well as the layman's viewpoint. At times the style is almost flippant, but as one accustoms himself to it and becomes increasingly impressionable it creates the mental pictures intended.

Dr. Steincrohn has made a contribution in "Forget Your Age!" There is many a man and woman short of fifty who has begun the process of self retirement, of closing the shutters of life about him, of frowning on the present and dreading the future. This volume should produce a reawakening in such an individual, or, falling short of that, at least create a sense of guilt within him. The physician needs to read this volume. He will realize better than ever before many of his patients' problems. He will gain a concept of certain phases of medical practise with which the medical school of yesterday did not concern itself too seriously. He will be reminded that he cannot drive himself indefinitely without a day of reckoning.

There are two chapters in this little book which are outstanding. The first, "It All Depends on You," emphasizes many of the evils of radio advertising and counter prescribing. It is an excellent discussion. The other, "The Old Men Return from the Wars," though written in 1944 is every word as true today as it was then. It briefly sketches the problem of the returning veteran. In the closing chapters the author is at his best. He even pulls out "from the bottom of the bag" a few pearls of wisdom, some quoted, the majority original. When the reader has read the last word and closed the book he will find it easy to believe with the author that "a happy old age is like coming into a safe harbor after a long voyage."

Read "Forget Your Age!" It will do you good. Then pass it along to a patient or to a fellow physician.

*MANUAL OF TROPICAL MEDICINE. By Colonel Thomas T. Mackie, M.C., Major George W. Hunter III, Sn.C., and Captain C. Brooke Worth, M.C. A.U.S. Philadelphia: W. B. Saunders Co.* 1945. 727 pp. 284 illustrations. $6.00.

Reviewed by Morris Tager

Reflecting the need stimulated by the war, the past few years have witnessed a great increase in the number of publications on tropical medicine. The present volume is one of a series sponsored by the Division of Medical Sciences of the National Research Council, and is a product of the Army Medical School, whose staff has been actively

engaged in teaching and research in this field. The book is far more than a "military manual," although the authors deny that it was their intention to supplant the standard texts concerned with this subject. The presentation of the material, while concise, and even brief, is well balanced, comprehensive, and quite thorough. Much recent data, as yet generally unaccessible, is incorporated in the text. The latest maps on geographical distribution of disease are reprinted. The illustrations are well chosen, many of them are original. It might prove helpful if later printing specified the magnifications of the photomicrographs. The epidemiological charts are diagrammed in a semi-popular manner, which may help the beginner to grasp the many complex life cycles. In the interests of economy, bibliographies are omitted. Basically, this volume is authoritative, sound, and up-to-date. Occasionally, the conciseness of presentation has led to an emphasis of one point of view to the exclusion of its possibly equally worthy rival. For example, in the treatment of intestinal amebiasis, the authors advocate the combined use of emetine and an oxyquinoline compound. They state that following the use of oxyquinoline compounds alone, in a high percentage of cases, the infection will persist. No concession is made to the point of view, supported by much evidence, that the oxyquinoline compounds may well be able to eliminate uncomplicated intestinal amebiasis without the use of emetine. All in all, this volume will undoubtedly serve as a very valuable addition to the literature on tropical medicine, and should prove equally usable in civilian as well as military practice.

*A TEXTBOOK ON PATHOLOGY OF LABOR, THE PUERPERIUM AND THE NEWBORN.* *By Charles O. McCormick*, A.B., M.D., F.A.C.S., Clinical Professor of Obstetrics, Indiana University School of Medicine; Consulting Obstetrician to William H. Coleman Hospital for Women, Indianapolis City Hospital, and Sunny Side Sanitarium. *St. Louis: C. V. Mosby Co.* 1944. 399 pp. 191 illustrations, including 10 in color. $7.50.

Reviewed by STANLEY B. WELD

Streamlining is paramount in the concise and direct style employed in this volume. The arrangement of the material is in the form of outlines with a minimum of textbook material added, very much as the lecturer would prepare his manuscript for presentation to a class of medical students. The author frankly admits that the volume is an outgrowth of a series of lectures prepared for the senior medical students at Indiana University. Selected references are inserted throughout the text in place of the conventional bibliography at the end of each chapter. To amplify the outlines, a large number of drawings and photographs have been included.

The volume is very well arranged. Under the heading *Pathology of Labor* are found all the factors described which contribute to abnormal labor, as well as a description of the various obstetric injuries, a discussion of post partum hemorrhage, and the indications, technic, advantages, objections, etc., of the various obstetric operations. Herbert Thoms' outlet pelvimeter is illustrated and his method of roentgen pelvimetry briefly outlined. *Pathology of The Puerperium* includes a discussion of puerperal infection, secondary post partum hemorrhage, breast anomalies and




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diseases, and various and sundry other lesser complications. The third portion of the book is devoted to *Pathology of The Newborn* wherein may be found accidents and injuries of the newborn, malformations, and conditions peculiar to the newborn. In this latter group is included a page devoted to erythroblastosis fetalis with a few references (of the hundreds available to date) on this subject. The *Appendix* includes obstetrical analgesia, including caudal, and a page of aphorisms worth reading, and more, worth remembering. Here are a few samples: "Of all branches of medicine, obstetrics at the top is the most sublime, at the bottom the most rotten." "'Intelligent waiting' is better than 'watchful waiting'." "Obstetrics is frequently more than a one-man job."

It is refreshing to find an obstetrical volume so replete with merit and not loaded with a collection of discussions amassed from decades of text books. Perhaps it is too brief but it assumes enough of an intelligent interest on the part of the reader to encourage and point the way to further collateral reading. There will be many prosaic midwives who will not be satisfied with highlights offered by this author. The book is up to date, for within its covers may be found reference to the use of Vitamin K, penicillin, stilbestrol, and the sulfonamides and an outline of the procedures employed in the Latzko and the Waters extraperitoneal sections. The various sterilization operations are described and portrayed in drawings. The author's foreword bears testimony to his constant interest in contributing to the solution of the problem of maternal and infant mortality.

## BIBLIOGRAPHY OF WRITINGS OF S. S. GOLDWATER, M.D.

The Bacon Library of the American Hospital Association has complied a bibliography of the published writings of the late S. S. Goldwater, M.D. Dr. Goldwater, who died October 22, 1942, was an outstanding hospital administrator and a leader in the progress of medicine. Although serving New York City as Commissioner of Health and later as Commissioner of Hospitals, the greater part of his professional life was spent as administrator of Mt. Sinai Hospital in New York City. At the time of his death, he was president of the Associated Hospital Service of New York City.

As a past president, and as a member of councils and committees of the American Hospital Association, he contributed an immeasurable amount to the art and science of hospital administration. Dr. Goldwater was recognized by an honorary membership in the American Institute of Architects because of his interest and ability in the planning of hospitals.

He wrote authoritatively on many subjects in the hospital and medical field and the bibliography is of use to those interested in studying the development of hospitals as seen by Dr. Goldwater. Copies of this 15 page index may be had without cost from the Bacon Library.

## Massachusetts Reports on Sickness Benefits

In November 1944 the State Advisory Council, Division of Unemployment Security, Commonwealth of Massachusetts, made an exhaustive study of sickness benefits and reported to the legislature of the State. The Council consisted of five members representing labor, business, and other interests. It held numerous hearings in all sections of the state and full discussions were encouraged. The Council also conducted several surveys and gave complete statistical tabulations of the results. It made some study of health insurance systems abroad. It studied thoroughly conditions in this country, and particularly in the State of Massachusetts, and gave attention to numerous experimental plans in the field of medical care.

The report concluded that there is no convincing evidence of pressing urgency for governmental compulsion. This would indicate that the need for such measures should be clearly established, when any type of compulsory governmental health insurance is proposed, federal or state.

The report established the fact that about two-thirds of workers surveyed are customarily receiving, from various sources, payments in events of illness and that the number and proportion is increasing very rapidly.

The report stated that, "as yet some of the basic and fundamental issues or questions have not yet been answered. It may be questioned, for example:

(1) Whether the broad concept that a (minimum of protection) against the major hazards of life should be carried over by the government into the field of illness.

(2) Whether a cash benefit for loss of income during illness is a separate, or even a major, phase of a Health Program.

(3) Whether anything but a major hazard should be provided for by governmental compulsion.

(4) Whether governmental compulsion is necessary until such time as it is clearly demonstrated that private enterprise cannot assume the responsibility.

(5) Whether the role of government should not be one of adding impetus to the establishment and expansion of private plans rather than in direct participation."

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VOL. IX JULY, 1945 No. 7

# How Shall We Obtain Our Postwar Physicians?

## PRESIDENT CONANT ON THE VETERAN'S EDUCATION

PRESIDENT JAMES B. CONANT of Harvard has expressed opinions on post war education of the veteran which differ from those of most educators. The education of the future physician is intricately involved in this problem. Harvard University's professional schools have agreed to continue the present wartime practice of waiving the formal requirement of a bachelor's degree for admission in so far as veterans are concerned, President Conant informs us in his recent report to the Board of Overseers of the University. He goes on to say, "Each applicant will be considered on his merits, and I believe the admission committee in each faculty will endeavor to select those among the applicants who show the greatest promise, rather than those who most nearly satisfy the prewar conditions in terms of academic study. Among the returning soldiers and sailors there will be certainly some brilliant and ambitious young men who would like to proceed at once with their professional training but who have had far too little college work—perhaps only two or three terms. Under an arrangement agreed to by the various faculties a limited number of such men of exceptional promise but insufficient collegiate preparation may be admitted provisionally to one of our professional schools and then enrolled in Harvard College for a few terms of study. If the college work prescribed by the professional school's committee on admission is finished with the honor grades specified in advance, the provisional enrollment will be final and the man proceeds to enter the Law School, the Business School or the Medical School as the case may be. It is expected that similar arrangements may be made between various of our professional faculties and colleges other than Harvard College."

Dr. Conant's appreciation of the situation is a realistic one. Farther on in his report he says: "I am firmly convinced that the ambitious, imaginative student whose college education has been interrupted by two, three, or perhaps even five years of war will be sorely tempted to forego further study and get established in a job." . . . "The man with brains and initiative may take one glance at the convential course which leads to a profession and decide it is not for him. We run the risk of losing the very men we need in law and medicine, for example, men of personal force, unless we can shorten the road that leads to a professional career. To do this we must sacrifice with reluctance some of the values inherent in a four-year college education which in normal times is a prerequisite for later work in almost all of our professional schools."

In a personal communication to the editor, Dr. Conant is more explicit on his views on the post war program in the medical school. He writes: "I think the Medical School, like our Law School, should go on a forty-five week, three term basis and by some drastic measures provide for taking in two or three abnormally large classes composed of the most able men among the veterans. In selecting these men for admission, every consideration should be given to the quality of the men; and as far as consistent with state laws, premedical requirements should be waived. I am very much opposed to the other type of selection which is now being pressed in professional medical quarters, providing an exempted group of young men headed for the profession. Providing a refuge spot from the Army and Navy by legislative action or administrative decree is to my mind to insure the wrong type of men entering the profession in the next year or two."

The G. I. Bill of Rights comes in for its share of criticism in President Conant's report to the Board of Overseers. "Fundamentally," he writes, "the Bill as finally enacted reflects the American public's dis-

trust of differentiation of educational opportunity in terms of talent or ability. Such differentiation is often spoken of as undemocratic. As a matter of fact, the original scheme with its selective features was quite the reverse; this is evident if one compares a program for providing professional education for veterans at government expense on the basis of demonstrated ability with the past procedures in this country in which the accidents of geography and parental income played the dominating role.

"Unless the law is subsequently modified, all our colleges, universities and technical schools will have heavy responsibilities when the wave of demobilized veterans hits our educational system. Unless high standards of performance can be maintained in spite of sentimental pressures and financial temptation, we may find the least capable among the war generation, instead of the most capable, flooding the facilities for advanced education in the United States. Such a situation would be detected before by the general public and the reaction against our colleges might be severe indeed. Therefore, I trust it will be made part of the record now that in its most important feature—the allocation of the amount of educational opportunity—the present law does not represent the desires of the educational institutions of the country."

Finally in regard to the post war college as it prepares for professional school, Dr. Conant writes: "On one thing many both here and elsewhere seem agreed, namely, that some radical changes will be required in the four year liberal arts colleges in the post war years." . . . "For those who enter the world of affairs or the professional schools of law or medicine, such preparation often proves too restricted a basis for the broad understanding of the problems of the modern world."

# THE SUPPLY OF PHYSICIANS

Williard C. Rappleye, m.d., *New York City*

The Author. *Dean, Faculty of Medicine, Columbia University*

It is difficult to understand the public statements that a shortage of physicians is imminent in this country. During the abnormal war situation there are shortages in every phase of national life. However, the medical schools of the United States are now filled to about 110 per cent of capacity including the first year classes opening in the fall of 1945. On the accelerated program, they are training an average of about 6,800 graduates per year, twice the number of physicians who die annually. During the period 1942-48 about 10,000 doctors more than normal will have been graduated because of the accelerated, war time program. Reliable actuarial studies by Selective Service Headquarters, and other authorities indicate that the present production of physicians will insure one doctor to every 733 people in the United States in 1950, twice as many physicians per unit of population of any country in the world previous to the war and well above the ratio generally accepted as sufficient for good medical care. While the matter of distribution and the effective utilization of these physicians is a separate problem, the fact is that the number of doctors will be adequate to take care indefinitely of all of the civilian needs and the probable military and public health requirements, if the services of physicians are used to their full advantage.

Much has been said recently about the deferment of high school boys to enter pre-medical education rather than the military services. Selective Service Headquarters, the War Department, the Navy Department, the Interagency Deferment Committee, and the late President Roosevelt have all recommended against such a procedure in the light of the overall manpower needs of the country. Even if it were to be adopted, such immature, young students would not be available for admission to medical school with even minimum preparation until the fall of 1947. It is fully expected that by that time there will have been discharged large numbers of servicemen who desire and should be given the opportunity, if qualified, to pursue professional training. In addition, there are a certain number of men who are not acceptable for military duty for one reason or another and also many well prepared women students who desire to enter medical studies.

Some of the medical schools have eight or more applicants for each first year vacancy for the October 1945 class and expect at least that ratio for the fall of 1946. It is quite possible that during 1946 some of the medical schools may not have as many appli-

cants as in normal times, but by 1947 there is every reason to suppose that the medical schools will have an adequate number of applicants as well qualified as war conditions have permitted.

The agitation recently to the effect that there will be a shortage of 35,000 doctors in the United States in the near future is at least disquieting, because any attempt to produce that number of extra physicians would require the creation of perhaps thirty new medical schools. Such a plan could only result in a serious lowering of the standards of medical education and medical services, which would be reflected for a generation. An over supply of doctors would lead to a deterioration of the standards and the ethics of medical practice. The present medical school facilities of the country are producing an adequate number of physicians and any attempt to dilute the proficiency and competence of the profession would be against the public interest.

These comments apply to the production of physicians and the recruitment of medical students and are not directed to the problems in other branches of science and the other professions. Medical education throughout the war has been preserved by the government almost completely intact, except for the shortened pre-medical college preparation and the abbreviated hospital experience, both of which were sacrifices for the war effort and which can readily be adjusted in the near future.

# COMMON BILE DUCT SURGERY: THE USE OF VITALLIUM TUBES

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The Author. *Associate Professor of Surgery, University of Rochester School of Medicine*

IN THE surgical management of disorders of the biliary system the group of cases having stricture of the common bile duct presents problems that may be very difficult to correct. In the cases of this type sent to our clinic for repair 90 per cent followed operative injury at the time of cholecystectomy. The question of why these injuries occur and how they may be prevented is pertinent. The following are common causes of common duct injury during cholecystectomy: inadequate exposure, inflammation or impaction of stones that shortens the cystic duct, strong traction on the gall bladder that tents up the common duct, anatomic abnormalities that confuse the relations, and blind efforts to control bleeding. The best way to prevent injury is to see the common duct clearly before clamping or cutting anything. If, then, the cystic artery is securely ligated, cholecystectomy may be done safely.

The end result of injury to the bile duct is stricture formation. It is to be emphasized that small strictures can be treated satisfactorily by excision and end to end anastomosis if normal tissue can be approximated without tension. Dilatation of the stricture, plastic repair and the Wilms-Sullivan operation are less satisfactory. Extensive strictures cause much more difficulty. The implantation of a biliary fistula has not worked well. The anastomosis of the hepatic or common duct to the gastro-intestinal tract is ofen done but has the disadvantages of stricture formation at the anastomotic line and of cholangeitis developing from ascending infection. Eliot[1] reviews 68 cases, of which 16 (23 per cent) were successful. The use of entero-anastomosis or of the antiperistaltic choledochojejunostomy of the Roux type should improve the results. But in cases where the latter type of anastomosis has been used after resecting carcinoma of the pancreas, cholangeitis does occur and cases seen at autopsy have shown infection. There is, as yet, no substitute for the sphincter of Oddi.

This report deals with the results following the use of Vitallium tubes[2,3] in the reconstruction of severely strictured bile ducts. Such a report is necessarily incomplete because of the war for many surgeons are away in the service and are unable to follow their cases. Another difficulty comes from the distribution of these tubes through commercial channels which gives no way of knowing who has

*From the Department of Surgery of the University of Rochester School of Medicine and Dentistry, Rochester, N. Y.*
*Presented at the Connecticut Clinical Congress, New Haven, September 29, 1944*

purchased and used them. I was only interested in their design so the manufacture, distribution and sale is carried on by the Austenal Laboratories, makers of Vitallium, who have marketed the tubes through surgical instrument dealers. Except where surgeons have reported their cases or have written to me about them the results are lost to analysis. It is hoped that subsequently many of these cases can be collected.

Vitallium was selected originally because work on the bones and joints had shown it to be practically inert in the tissues. Animal experiments revealed absence of irritation when used in the biliary tract. The tubes, though thin walled, were very strong and their polished surface was resistant to corrosion by the bile. Vitallium has the drawback of being very hard so it cannot be bent, moulded, or adjusted at the time of operation. It is so hard that it cannot be machined and all work must be done by casting, welding and polishing. This is time consuming and expensive. The use of other alloys has been considered but none have been found to be completely satisfactory. For instance, Tantalum, which is also inert in the tissues and is softer so that it can be worked easier, cannot be welded. Thus no anchor can be firmly attached to the tube. The use of other substances such as rubber, glass or plastics has appeared impractical because of adverse tissue reaction to them.

These tubes were intended to hold open a strictured area in order to maintain the continuity of the bile ducts. In some cases the inability to locate the distal end of the common duct has led to their use for anastomosing the hepatic duct to the intestine. They were never intended for this so are poorly designed for it. The end inserted into the bowel is too long and protrudes into the lumen too far. It is probable that tubes should be made with one short end that would fit better into the intestine for there will be occasional cases where this is the only type of anastomosis that can be done.

### OPERATIVE MANAGEMENT

The question is often asked, "How do you go about finding the ends of the ducts in the mass of scar tissue that is present?" Some experience has been gained in this so it may not be out of place to describe the dissection. All the cases have had previous operations often followed by infection or biliary fistula so the adhesions are dense and scar tissue has often obliterated many normal landmarks. The cleavage plane on the undersurface of the right lobe of the liver is followed and freed of adhesions, the upper border of the duodenum is defined and mobilized, and the lateral edge of the gastro-hepatic omentum is dissected free. This permits exposure of the field. The scar of the gall bladder bed is seen to blend with the gastro-hepatic omentum. Just above this point or higher in the cleft of the liver will be found the common hepatic duct. If a biliary fistula is present, it leads one to the duct; otherwise the scar is divided until it is located. Often stones, sediment and bile under pressure escape when the duct is opened. It should be carefully examined to be sure of its patency and to locate the openings of the right and left hepatic ducts. Then comes the hard job of finding the lower end—the common duct. Sometimes it is nearby but more often it has retracted so that the ends are an inch or more apart. Careful, patient dissection that divides the scar of the gastro-hepatic omentum will usually locate the empty collapsed duct just above the edge of the duodenum. In one case after an hour's search during which the portal vein and hepatic artery were freed and no duct found, it was finally located on the undersurface of the duodenum which was being retracted for exposure! It is unfortunate that no easier method has been devised for locating the lower end of the duct. Retrograde probing through the ampulla of Vater was thought of but often the ampulla cannot be found for there is no bile coming out of it. One is reluctant to open the duodenum unless there is a reasonable chance of expediting the operation.

Dissection in the dense scar tissue while searching for the duct may jeopardize the portal vein for they often lie close together. This relationship led one surgeon to object to the use of these tubes on the theoretical basis that the hard metallic object might press on the portal vein and so increase the portal pressure or even erode into the vessel. This has never happened. I have opened the portal vein in one case and was able to control the hemorrhage and repair the defect. A week later the patient had recovered sufficiently to allow reoperation and I did not hesitate to place a Vitallium tube in the duct beside the suture line in the portal vein. As was expected no harm came from this and the patient not only recovered completely but has remained well.

Vitallium tubes have been successfully used to bridge a gap between the separated ends of the bile ducts but there is always danger that they may slip out. It is preferable to suture the ends of the duct together over the tube and this is usually possible

if the ends are mobilized. It is easier to fix the upper end of the tube firmly in the hepatic duct before passing the lower end into the common duct for there is more room to work below and the final suturing of this part is less hampered.

RESULTS

Thirty-seven cases are available in which the end result is known; seventeen of these are from this clinic, the remainder being cases that have been reported to me by other surgeons. There are undoubtedly many more about which I do not know.

Eight of these cases had a Vitallium tube used to anastomose the bile duct to the intestine and in three of these the tube was passed into the bowel. Subsequently, a stricture formed at the site of the anastomosis requiring reoperation and reinsertion of a tube. This is one of the disadvantages of duct-intestine anastomosis.

In one of our cases where a tube was used to bridge a gap[2] it pulled out and had to be reinserted at a subsequent operation. This patient is now well.

Six cases have had plugging of the tube by deposition of sediment in the lumen. One of these was from our group and through the cooperation of Dr. S. H. Bassett the composition of the sediment was determined to be as follows:

| | |
|---|---|
| Weight of material after drying | 0.4319 gm |
| Chloroform soluble portion (cholesterol) | 0.1664 gm |
| Chloroform insoluble (mostly bile pigment) | 0.2655 gm |

This low level of cholesterol is surprising for it was assumed to be the cause of the obstruction. This idea was strengthened by experience in two cases who developed jaundice which was relieved by giving sodium taurocholate. It was believed that this drug had increased the solubility of cholesterol and dissolved the plug in the tubes. It is probable that the cholesterol content varies in different cases and since it is most apt to be the cause of obstructing the tubes it appears desirable to give sodium taurocholate to all cases at intervals.

The most encouraging fact in this situation is the finding of reconstruction of the duct to a normal calibre and restoration to normal appearance after 26 months. In this case the plugged tube was removed and not reinserted.

E. H., S. M. H. No. 171848.

A 54 year old female diabetic was operated upon elsewhere on May 22, 1940, for acute cholecystitis. The report reads: "Clamp on cystic duct by touch and gall bladder was removed. The cystic artery apparently slipped out of the clamp and there was difficulty in stopping the hemorrhage. It was finally clamped and ligated." Three months later she developed jaundice, chills, fever and vomiting.

On May 29, 1941, she was first explored here and a stricture of the common hepatic duct dilated followed by removal of stones from the right hepatic duct. Jaundice returned September 1, 1941, (three months postoperative).

On October 1, 1941, I operated upon her finding a stricture which was "so dense that the smallest probe had to be forced through it." This stricture was at the bifurcation of the two hepatic ducts. It was dilated and a Vitallium tube inserted.

The patient remained well for over 2 years but on November 18, 1943, developed jaundice. She was re-explored December 24, 1943. The Vitallium tube was removed and found to be firmly plugged. The region of the stricture was inspected. "To the operator's amazement, it was found that the duct would admit a No. 18 catheter easily and that the lining of the duct was smooth, velvety mucosa which was perfectly normal in appearance." It was a great temptation to remove a small piece of the duct wall for microscopic study but I was afraid this might constrict the lumen. The opening in the duct was sutured and the patient recovered uneventfully. When last seen, on September 26, 1944, 9 months after removal of the tube she was well.

This is a very hopeful finding for if the duct will reconstitute over the tube and regain a normal calibre and mucosa, it will not matter if eventually some tubes plug. They will have served their purpose.

NOTE AT THE TIME OF CORRECTING THE PROOF

In the interval since reading this paper I have received from most of the members of the American Surgical Association letters giving their experience with the use of the Vitallium tube. This has permitted the collection of 208 cases for study. A detailed report will be made from these data so only a summary is given here.

(1) 106 cases had repair of the bile duct by means of a Vitallium tube. The results were good in 85 cases (80.1 per cent). In the remainder the commonest cause of failure was plugging of the tube in 12 cases (11.3 per cent). 7 cases who had the tube used to bridge a gap were all failures.

(2) 79 cases had a Vitallium tube used to anastomose the bile duct to the duodenum. 46 of these

(58.2 per cent) had a good result. In 30 cases (38 per cent) the tube is known to have passed and in 27 of these (34.1 per cent) this was the cause of failure.

(3) 18 cases had a Vitallium tube used for anastomosis of the bile duct to the jejunum either with a Roux Y or a loop with enteroanastomosis. 15 cases (83.3 per cent) had a good result, yet in 7 of these (38.8 per cent) the tube is known to have passed.

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# CONTROL OF ENVIRONMENTAL HEALTH HAZARDS

Allan L. Coleman, *Hartford*

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Recalling the numerous cases of tetrachlorethane poisoning, radium and other poisonings which resulted from exposure to toxic materials associated with the production effort during World War I, we realize that considerable progress has been made in our ability to recognize and control environmental health hazards. Many of the basic principles having been established—industry, the medical and nursing professions, labor, army and navy services and governmental industrial hygiene units are now coordinating their efforts in applying this knowledge and experience to keep the worker on the job and to keep him well.

During the earlier stages of this war, when industry was gearing up for all-out production, numerous courses and seminars were organized and attended by industrial physicians, safety engineers, nurses and other personnel responsible for the health and safety of the worker. The industrial hygiene units in 38 industrial states have been advised whenever government contracts were issued. This information not only provided the names of plants undertaking war work, but also indicated many changes from normal operations with the possible introduction of unfamiliar materials and new health hazards. Plants receiving such contracts were listed for immediate contact and have constituted an important portion of the bureau's field work. In most instances, plants undertaking new work were completely surveyed—from the receiving department to the shipping platform.

An industrial hygiene survey at a plant means careful observation of all operations in each department for conditions or operations which may present health hazards. Though the purpose of the survey is chiefly concerned with exposures to atmospheric contaminants as dusts, fumes, mists, gases and vapors or irritants which may cause dermatitis, the industrial hygienist also makes note of abnormalities of temperature, humidity and pressure, radiations, repeated motion, tension, etc., excessive noise, inadequate general ventilation, drafts and other physical agents which may adversely affect health and production. Accurate information is obtained, either from plant personnel or by actual laboratory analysis, as to the composition of materials used or produced in the various operations and processes. Some of the materials which may contaminate the workroom air may be very harmful, while others are relatively non-toxic. Dusts containing silica, lead or cadmium, for example, present serious health hazards; while limestone or coal dust may be considered relatively non-injurious. Cadmium and lead fumes are very toxic; zinc and magnesium fumes are not. Hydrogen sulfide and carbon monoxide gases are dangerous. Ammonia gas is primarily an irritant. Benzene, tetrachlorethane and carbon tetrachloride are among the more toxic vapors; while acetone and ethyl alcohol vapors are relatively non-toxic. Threshold limits, or maximum safe concentrations, have been established for many of these materials. With these values in mind, the industrial hygienist judges whether or not a given operation presents a health hazard. In case of doubt he suggests that a detailed environmental study be made. Instruments

*Presented at the Joint Conference on Industrial Health and Safety, New Haven, December 14, 1944*

which give immediate results are frequently used during the preliminary survey in estimating atmospheric concentrations of dust, gases and vapors. These results together with air velocity determinations at the face of spray paint booths, over dip tanks or along the lateral exhaust slots of plating tanks frequently provide sufficient data to determine the extent to which the health hazard is controlled. After making a complete plant survey, the industrial hygienist is in a position to judge whether health hazards are presented; whether certain operations require further control or whether additional medical, engineering or chemical investigation is indicated. After completion of follow-up work, including recommendations for necessary control measures, the plant is scheduled for periodic resurveys.

Recommendations for the control of atmospheric contamination may be based on observations made during a general plant survey or on the results of a detailed chemical study. Certain industrial operations such as sandblasting, rubber cementing operations with cements containing benzol, cleaning operations using carbon tetrachloride, cadmium melting, chromium plating, anodizing, etc., are known to present serious health hazards unless effective control measures are employed. Inadequate control of these types of operations would be apparent to the trained industrial hygienist during the plant survey. Operations such as spray painting in large open areas, silver soldering, rock crushing, fabric coating in partially ventilated units, paint drying, grinding, and many others may or may not present health hazards. The necessity for control measures in these instances depends upon the materials used or produced in the atmosphere and upon the manner in which the operation is conducted.

Where the need for control is indicated, it may be accomplished by:

(1) Controlling the dust, fume, vapor, gas or mist at the point where it is produced in the atmosphere. This is commonly done by the use of local exhaust ventilation, the use of wet methods or by changing technic of operation.

(2) Good general ventilation, in which case the contaminant in the air is reduced to safe concentrations by dilution with clean air.

(3) Isolation or segregation of operations, limiting the exposure to one or two persons provided with adequate respiratory protection. This type of control may be illustrated by the sandblaster, in a completely isolated room, wearing a helmet with clean air supplied.

(4) Substitution of less toxic materials for those of higher toxicity may sometimes be feasible. This method has been utilized in the rubber fabricating industry by substituting naphthas for benzol in the cements, in the substitution of non-mercury for mercury carrotting solutions in hatters fur preparation, and steel shot and grit for silica sand in abrasive blasting. This method, however, does not have the wide application of the others previously mentioned.

(5) Respirators of the supplied-air or air filtering or purifying type may be used effectively where short, intermittent or irregular exposures occur, such as in clean up, maintenance or materials handling work. Though respirators are available which have been approved for protection against most atmospheric contaminants, this method should not be considered an adequate substitute for ventilation.

In addition to the above, it is important that good housekeeping practices are observed and that control equipment is properly maintained.

The following are a few operations of war-time importance in which it has been found necessary to employ one or more of the above methods to effectively control health hazards:

### RUBBER CEMENTING

Benzol and toluol were used in large quantities in rubber cements during the earlier part of the war. Atmospheric concentrations of benzol and toluol were reduced to safe limits, 100 and 200 parts per million respectively through local exhaust ventilation at fabricating benches and through controlled general workroom ventilation. Naphthas now have been substituted for this operation, though chlorinated hydrocarbons, toluol and methyl ethyl ketone are used in the cements for various types of synthetic rubber products. Atmospheric concentrations of 200 parts per million are considered safe for these solvents.

### LEAD CASTING

Local exhaust ventilation at lead melting pots is usually essential to keep atmospheric concentrations of lead dust and fumes below the maximum safe limit of 1.5 milligrams per 10 cubic meters of air. The careful handling of dross is also essential. Various mechanical operations in the bullet manufacturing industry have been shown to produce sufficient lead dust in the air to require exhaust ventilation for control of the hazard.

BALLISTIC TESTING

Carbon monoxide, silica dust, lead and oxides of nitrogen are potential hazards associated with test firing ranges used in arms and munitions manufacturing. Mechanical exhaust ventilation at the firing end of the range and at the pit are being used to control these hazards.

METALLIZING

The extent of the health hazard associated with this operation depends upon the toxicity of the molten metal being sprayed. Local exhaust ventilation and the use of an air-supplied respirator are essential in controlling the health hazard produced by the use of such metals as cadmium and lead. Local exhaust hoods at the point of operation have been shown to be effective for the control of iron fumes.

SILVER SOLDERING

Studies have failed to show atmospheric fluoride concentrations greater than three parts per million in the vicinity of silver soldering operations where the fluoride flux used contained no appreciable amount of free acid. Fluoride fluxes showing high acid values, however, will result in atmospheric fluoride concentrations sufficient to cause upper respiratory irritation and nose bleed. Local exhaust ventilation is recommended in these instances.

Considerable interest has been shown in the study of fluoride exposures. Some investigators have concluded that no apparent injury results from exposure to those concentrations which do not cause nasal irritation.

WELDING

Injurious concentrations of welding fumes and gases are seldom encountered in open areas provided with good general ventilation. Local exhaust ventilation should be provided when any of the more toxic metals such as lead, cadmium or mercury compounds are present. These materials are sometimes present as coatings or paints on the parts or structures to be welded.

Mechanical exhaust ventilation should be provided when welding is done in confined areas such as in tanks or ship hulls. Flash shields and goggles should be provided for the protection of welders and neighboring workers from infra-red and ultra-violet radiation.

RADIUM DIAL PAINTING

The control of exposure to radioactive dust and radon may be accomplished by limiting the amount of radioactive materials issued to the workers, the provision of suitable enclosures and mechanical exhaust ventilation, and through strict observance of housekeeping and personal hygiene measures. Gamma ray exposure may be controlled by using lead screens or by storing materials to eliminate high gamma ray concentrations in any working area. It should be remembered that distance is the best protection against gamma rays, as intensities vary inversely with the square of the distance. U. S. Bureau of Standards Handbook H-27, "Safe handling of radioactive luminous compound," contains detailed information on this subject.

METAL CUTTING OPERATIONS (CUTTING OIL)

Numerous laboratory examinations have been made of cutting oils in an effort to discover any predominating chemical factor in the production of oil dermatitis. The acidity and alkalinity of these oils have been found to cover a range from a pH value of less than 2 to as high as 10.5 or 11. Contamination from alkalies adhering to treated metal parts were responsible for the high pH values, though unused oils have shown high degrees of acidity. Materials used as disinfectants, such as phenolic and cresylic compounds, formaldehyde and nitrobenzene, have been found in oils where the dermatitis problem was receiving considerable attention.

In several instances oil on metal parts was found to contain bichromates absorbed from the parts subsequent to a bichromate dip. The addition of a water rinse tank, after the bichromate dip, eliminated the dermatitis problem. Good personal hygiene and the use of protective clothing, where practical, are still the most generally effective measures for preventing oil dermatitis.

HEAT TREATING

The use of lead pots, particularly with bath temperatures in the vicinity of 1500°F have been found to disperse toxic concentrations of lead fumes. This is well known by industry, with the result that practically all such installations are adequately hooded and exhausted. An interesting development is the use of fused salts, or a layer of charcoal about 2 inches thick, as a covering for the surface of the molten bath. This procedure has been found by chemical study to control the dispersion of lead fume so that any exhaust control measures applied function primarily for the removal of excess heat from the working area. Undue agitation or partial

removal of these layers will reduce their effectiveness.

CHROMIUM PLATING

Chromium plating, as a finish for hardware and similar products has been practically eliminated since the beginning of the war effort. However, many tanks have been in operation throughout the state on an industrial basis. Now that some civilian products are being released, several inquiries have been received regarding the ventilation of new or reconditioned equipment to control the dispersion of chromic acid mist. New developments in the design of such exhaust systems are being suggested in considering these installations.

These examples of a few industrial operations show how specific measures are used in the effective control of environmental health hazards. As new materials and processes are introduced, it is our responsibility to determine whether new health hazards will be presented and whether present control measures will be adequate for materials which may be more toxic than those previously used. Although we should like very much to be able to substitute in the direction of lower toxicity, there is usually very little choice in the matter. There are very few toxic substances that cannot be used safely if we understand the potentialities with which we are dealing and exercise good judgment in the development of control measures.

Personnel responsible for the protection of life and health in industry has achieved new records during the past few years of all-out production. Intensive courses of instruction have been attended by medical and safety personnel, and much has been accomplished in coordinating the efforts of medical, engineering and personnel workers in the reduction of lost time through illnesses and accidents. Let us continue our efforts in this direction for the improvement of the general health level of the industrial worker who is now active on the home front and for the benefit of those returning from the battle fronts to civilian life.

# MENTAL PROBLEMS AFFECTING INDUSTRIAL WORKERS

## With Special Reference To Veterans

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THE primary purpose of industry is profit. To attain that purpose the industry needs money, machines, materials, markets and above all—men, men of different classes, capacities and training, so coordinated as to make a smoothly functioning organization. If a workman is well physically, mentally, and in his relationship to others, he is an ideal worker. Everyone in the industry is not such an ideal, because many lack either physical or mental health, or have difficulty fitting in with others.

A man does not work with his body alone, rather, he operates as a total unit; his body being a tool of his mind. If there is any upsetting condition within himself or in his relationship with others, his mind is disturbed, and his whole efficiency impaired. It is wrong to assume that his mental problems are his personal business, and that the industry is only interested in his productivity. Does he produce through his body alone and not through his mind? Sometimes it's expected that the man, on coming to work, should leave his personal problems without, as if the functioning of the body and mind could be separated. There is close unity between the two, and when either part is effected, the whole organism suffers.

Many nervous and mental problems exist in every industry and go unrecognized and untreated, thereby contributing largely to the major difficulties in the plant such as inefficiency, waste, friction, accident proness, absenteeism, rapid labor turnover, even difficulties between labor and management. All the mental illnesses are not insanities. It is earnestly hoped that this point is clear and definite, and that we will keep this distinction in mind as we go on with this conference.

*Presented at the Joint Conference on Industrial Health and Safety, New Haven, December 14, 1944*

If a confusion in the terms exists, the fear of the industry is justified that, in employing a mentally ill individual, they are taking a big risk; and that some day that mentally ill individual may become violent, destructive and homocidal. Except in rare instances the industry does not face the problem of dealing with the insane; whereas, it daily faces hundreds of mental illnesses of different types, often more vicious.

How common are mental illnesses? Of the 15,000,000 men examined for the Army there were 4,500,000 that were rejected, of which, the nervous and mental diseases were by far the largest single cause. Out of every 100 men examined about 15 fell in this class. The non-insane made up 90 per cent of neuropsychiatric rejections. Our basis for rejection of these men for military service was that they were so handicapped that they could not adjust themselves to the various complexities of Army life. If accepted, they might have broken down or become a grit in the smooth operation of the military machine. So far 1,500,000 veterans have been discharged and the rate of discharge continues at 20,000 per month. In Connecticut, we have on our hands about 120,000 whom the Army could not take, or after taking, could not use. Of these 120,000 about 50,000 are mentally handicapped. When you include similarly handicapped individuals among women and the men in the older age groups, where other causes produce a greater number and variety of nervous illnesses, we estimate that there are about 150,000 to 200,000 people who are not mentally well. Yet because of the pressure of war and shortage of manpower, it has been forced upon the industry to employ such men and women who would ordinarily be considered unemployable. The conditions of housing, over-crowding, improper diet, prolonged hours, irregular shifts, restrictions of pleasures and outlets have taken a larger toll among these people of marginal health. Total result of employing these handicapped people under these adverse conditions has been much loss of time, effort and a lot of waste.

Although requirements of the industry are not as high as those of the Army, and the adjustment to industry is easier, it is reasonable to say, however, that the man that could not fit into military service would still have some difficulty in fitting in the industry. Some of the rejectees have been the best workers, but the majority of the neuropsychiatric rejectees and rejectables are problems.

What are the types of mental illnesses we meet? The organic diseases of the brain and nervous system are rare: and epileptics, uncommon. One large group is the mentally defective. This group also, is of no interest to the industry, since the idiot and the imbecile fall below the mental age of 8 years, hence are unemployable. The moron with the mental age of 8 to 12, usually adjusts well to simple routine jobs and hardly ever causes trouble.

The first in the group of particular interest and concern to the industry is the insane; known as such to the psychiatrist, but either unknown to, or considered just queer by the management. Many large industries have individuals of this type who do excellent work. In my own practice, at any one time I may have a dozen or more people that are insane enough to be commitable to an "asylum," but who under supervision and treatment carry on work very satisfactorily. Their continuance at work is of the greatest rehabilitation value. It makes them get well faster. So far none of these patients has caused any difficulty. This is no recommendation for indiscriminate employment of the insane, nor for the industry to be an adjunct of psychiatric practice, but it is a recommendation, that if a case of insanity is known, understood, and under supervision he should be employed without a sense of risk or danger. These people should be considered on their performance and not on their diagnosis.

The next group is the so called "psychopathic personality," who may even be brilliant, but cause considerable trouble because they have quick and violent tempers, are emotionally variable, have little aim or purpose in life, do not stay put, carry a chip on the shoulder, lie glibly and are irresponsible. In this group are most of the drunkards, addicts, bums, hoboes, the shiftless, the sex perverts, the criminals, some of the agitators and chronic trouble makers. As a group they are a bad lot. They give far more trouble than the insane.

By far the largest group with the greatest variety of symptoms are the so called psychoneurotics. These people have problems and difficulties that are expressed in bodily symptoms, emotional disturbances or abnormal behavior. As in private practice so in industry, more than 65 to 80 per cent of those who seek medical advice repeatedly are psychoneurotics. They have pains and upsets; become tense or depressed; suffer from fear, anxiety or sleeplessness. Their minds are always on their symptoms and their symptoms perpetually on their tongues. They are forever "bellyaching." This group represents not only the largest, but the most ill understood, and ill treated group in the whole popu-

tion, and hence in the industry. As a group, they ake up about three-quarters of all nervous and ental illnesses.

Just as in the Selective Service examinations all the jectees did not come from the lower social, eco- mic and educational strata, and all rejections from e military service were not limited to low ranks, to those coming from the underprivileged class, in industry, the mental illnesses are not limited the labor class. Men underneath are much alike ith the same mental mechanisms, with their own culiar difficulties, reacting alike to strain, fatigue, somnia, disappointment, friction and bodily ail- ents. All, regardless of class, have personal, domes- and financial problems. The goals may vary but striving for them, all suffer alike from frustration. is rather the make-up of the man in respect to s heredity, environment and personal experiences at determine his susceptibility or immunity to sanity. Man to man, the total personality assets d liabilities in one group are not different from e other group. Therefore, I don't only imply, but ate as a fact, that the supervising, the managing d the directing groups in the industry are just liable to serious mental illnesses of all kinds as the worker. There is a great difference, however, hen one of the leaders has a mental handicap. ecause of his commanding position, such an indi- idual, when sick, will have far greater effect on the isturbance of the industrial organization than a orkman, since the official supervises men, whereas, e workman handles a machine.

As we see similarity of mental illnesses among the arious civilian classes, we find difference between e civilians and veterans, not only as to type of lnesses but more importantly in the psychology of he two. Since the defectives, the epileptics, the sychopathics were eliminated in Selective Service xaminations, they are more common among the ivilian workers and nearly negligible in the veter- n group. The discharged veteran group, however, as a higher percentage of insanities. Among one roup of two thousand dischargees, 40 per cent were nental, 7 per cent insane. With the new im- roved methods of psychiatric treatment the num- er of the insane staying in the veterans hospitals will be smaller, at the same time increasing the load n the society and the industry. Among the soldiers he mental illnesses are often more serious than same llnesses among the civilians, yet because the soldier's ase is understood, it is easier to handle in readjust- ng him to work. With some of the soldiers their record of mental illness is a definite handicap. They feel the label, the stigma, and act condemned, whereas the civilian having the strictest confidence in his private physician feels secure.

The veteran's mind works differently. As result of his sacrifices in changing from a civilian to military status and his various experiences in service, his personality changes. Upon his return from service he goes through an even more difficult job of readjusting. He might be geographically dislocated, his family relationship broken, his loves and attachments strained or lost, material and moral values altered. In changing from Army to civilian he often becomes demoted; sudden relaxation of discipline finds himself in a mental rut, without ambition, interest or goal. He has lost opportunity, feels insecure, refuses to yield to civilian authority, considers himself a hero and expects that the country owes him something.

Against these serious handicaps he has great advantages: 1. Federal and state laws give him various benefits and liberal provisions. 2. Many bureaus, agencies and committees are set to guide him. 3. Health and welfare servicse will look after him and his family. 4. An eager and willing industry nearly turning itself inside out will put him on a job.

In my psychiatric work with veterans I find them falling in various classes. 1. Those who make no demands. Upon discharge they return home take the easiest way of life, doing nothing, just hanging around and depending on their families for support. In them the drive is gone; they are satisfied with the least in life and want to be left alone. 2. Those who want something for nothing. You often hear the remark—"I can't work, or do hard work. It is up to the government to look after me," or like the fellow with a Post Office job making over $50 a week who thinks that after the war the competition will be too keen, he won't he able to carry on, so he has started on a plan for getting full compensation in case he loses his job and can't get another. If this man were to put as much of his time, effort and thinking into his work as he does on his case he would establish an excellent security which is the thing he looks for. 3. Those who start work, but can't stick it out because they have little emotional reserve, become discouraged, dissatisfied or annoyed. They change from one job to another or go from one industry to another. They think that the industry must find a place for them because they owe it to them. 4. Those who are over ambitious, want to make a lot of money, advance fast, or expect responsibilities

beyond their capacity. When conditions do not permit these, they quit in bitterness, resentment and disgust.

The question is how to deal with these difficulties affecting the civilian as well as the veteran. I do not advocate that everyone in the industry with some nervous difficulty should go to a psychiatrist. Many of them need not even go to the industrial physician, or even the nurse. The greater majority of the problem cases could be very adequately and happily handled by the employment manager, foreman, the supervisor, the personnel director; but these key men need enlightenment and education on understanding and handling such people. Above all they need to be human with patience and kindness toward the people under them. When any problem arises, the application of the golden rule will solve nine out of ten problems. Many times giving such a case just a chance to unburden, will take care of the situation. The nervous and mentally sick complain that the management is not interested, doesn't listen or care. The solution is obvious. If the supervisors can only show interest, listen and give evidence of caring, a surprisingly large number of problems will be eliminated at the start.

It is important to emphasize here, that the expression that someone's symptoms are imaginary is too frequent, too unwise and too harmful. It is used even by physicians. In their case it is even less excusable. Psychoneurotic behavior is not within the control of the sick. Invariably they feel what they complain, and where they get no sympathy, insult is added to injury. In many a situation, a surgeon, excellent in judgment and technique of operation, vitiates his result by too practical and tangible thinking, and does not give enough consideration and thought to the way the sick and the injured feel, and what underlying problems they have. Many cases of prolonged convalescence from operation and injury are principally due to lack of understanding between the patient and the industrial surgeon.

Too many times, too much attention and treatment is directed to the workman's body, when the real cause of that problem is psychological. When bodily symptoms are of psychological origin, direct physical or purely medical treatment, especially of prolonged character, always aggravates the situation. The explanation for this is quite simple. A light to the back, a pill in the stomach will not help if the trouble is in the "head." Since the man doesn't know that his symptoms are psychological he continues to have them in spite of the treatment. The sick man's symptoms are his only tools of defense. You try understand him you will disarm him, when you t to take his tools by threat or force, he will contin to use them and develop new ones. Hence it is a wi practice to set a limit to the scope of medical trea ment when there is ground for suspicion that t case is complicated by mental factors.

For best handling of nervous and mental illness in industry as in private practice we need a goo history, a thorough examination and competent ma agement. To apply these to industrial problems Connecticut I suggest establishment of a centr office in the state where is kept on file the reco of every employable man and woman in respect t his work, nervous and mental illness, and h health in the Army. We already have much of th information in the man's draft record. The Dra Board, the Veterans Administration, Employme agencies, or other sources that have knowledge o the worker should pool their information in th central office making it available to the industry o any agency that is interested. This will be to t workman's advantage, because when his case histor is fully known it can be used to the best mutu advantage and for better protection of his healt

In the course of his employment a thorough phys cal and a neurological examination should be mad looking for diseases of the brain and nervous systen All other available laboratory aids should be use when indicated. Through intelligence tests and pe sonality study, self administered or conducted by lay person, many of the unemployable mental defe tives or psychological abnormalities will be detecte After acceptance for work, every employee's me tal health should be as much a matter of concern t everyone in his management as is his physical healt and safety.

A man spends most of his wakeful hours at wor It is a simple matter to know if a certain individu does not feel or act well, when he is seen every da by many people and under variety of conditions. T best recognize the mentally ill, the foreman, th supervisor, the personnel director and others wh deal with him, initially selected as to interest, under standing and leadership, in addition, ought to b given an orientation course in observing, recognizin and handling of nervous illnesses. Call this making o them amateur psychiatrists if you will. Is this differ ent from First Aid men in industry who do such fine job with physical injuries? I am convinced tha the supervisors feel anxious and eager for suc instruction. Through a course of simple lectures, us

pamphlets, case discussions and practical demonrations these people can be trained to handle the reater majority of cases. If the man is properly zed up, put on a job that fits him, and the pervisor has done his best to help him get ong, he continues to have difficulty, then he ould be seen by the industrial physician. If is psychologically inclined, and he ought to be, any of these difficult problems can be solved by m. When a situation finally arises, where above ethods have failed, the man is entitled and the dustry is under obligation to have him examined y a competent psychiatrist. The time for such an xamination is early and not when the difficulty is lly established and the man is a casualty. In psyiatry an ounce of prevention is better than a term a "crazy house." Every individual whether a oldier, worker or civilian prefers by far to be under he care of a private psychiatrist than under the care f a Veterans Administration or a clinic. They feel a ersonal interest, greater confidence, and closer retionship, which all go to make a good rapport. Vithout such a rapport the psychiatrist can not ccomplish much with the patient. The treatment ould be carried out on individual basis, but if the umbers were large and could be segregated, the ractice of group psychiatric treatment, so well emonstrated in the Army, could be readily applied o the industry.

The experience of several large industries has lready shown the great values and practicability of aving a psychiatrist's services available, on a full, r part time basis, or even on a consultation basis, epending on the size of the company. Whatever he position or relationship between the psychiatrist nd the particular industry, his job should not be nly to examine and treat patients, but more importntly, he should organize and conduct a general ducational program for the plant.

What does industry get out of all this effort? In neeting these various problems, the industry must ot feel that it is being asked to do missionary or velfare work, rather, to contribute its share to the eneral social welfare. The handicapped soldier or ivilian does not want pity or charity, rather, he eeds sympathy, understanding and a chance to be elf-supporting. In the case of the soldier particulary, pampering and coddling are very harmful and hould never be resorted to by the family, society or ndustry. In providing them jobs it helps them to nake a decent and respectable living, rather than llow them to be on a dole, the cost of which indirectly and finally comes out of the industry. In meeting these needs the industry makes an investment for its own good in material gain, because a healthy, happy, satisfied and willing employee is a safer, more efficient and more productive employee. Among the men there is a feeling of team work. When more goods are put out in lesser time with lesser waste, the profits are greater. For such greater returns as social betterment, better morale, and greater profits the industry needs to spend a very little sum. This is only mentioned if the cost of such service is a major consideration with the management. This effort for maintenance of morale and productivity is an infinitessimally small fraction of what is spent for maintenance of the plant. Yet in doing so the industry prevents many evils and difficulties among workers and eliminates unnecessarily long convalescence from illnesses.

What the industrial psychiatrist advocates is not an experiment, since the results, where tried, are proven. Even if looked upon as an experiment, again the industry is not expected to spend more than a fraction of 1 per cent that it spends on experiments on machines, materials or markets. Remembering again the importance of the man's mind and its health such an expenditure is a very wise investment since it is the mind that runs the man, that runs the machine, that puts out the material, that flows to the market, that brings the profits.

SUMMARY

In conclusion, we see that the industry has among its employees a surprisingly large number and variety of mental illnesses, and because of no care or plan for these problems they go unrecognized, thereby causing an alarming number and types of difficulties which handicap smooth and efficient operation of the plant. These mentally handicapped come from all ages, stations, and classes. The bigger the fellow so handicapped more disastrous for the plant. The problem of the returning veteran is in the lime light but it should not force the greater problem of the civilian from attention. The major nervous and mental difficulteis are described with some emphasis on the psychology of the returning veteran. It is shown that those properly selected for the positions of leadership, after psychiatric orientation and training, can, not only recognize, but also correct the trouble at the source. They, failing, will pass the problem on to the industrial physician and finally, if necessary, to the psychiatrist who should be on the consulting staff of every modern industry.

In the past we have not looked for these problems, and now that we see them, let us not get alarmed, but be prepared to handle them to the advantage of the man, the industry and the society. The role of psychiatry in industry is a new one, but it has tremendous possibilities and opportunities to do great good. The psychiatrist's interest and help is not on in the individual himself, but in his relationship wi others. It is the harmonious relationship that spe success in every collective human effort, particular in the industry.

# MANAGEMENT'S VIEWS CONCERNING THE EMPLOYMENT OF PHYSICALL AND MENTALLY HANDICAPPED WORKERS

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In the past the employment of physically and mentally handicapped workers has not been a very serious problem. It is true we have had handicapped persons employed in our factories. They have been placed in jobs which they could do. However, from now on we may be called upon to place thousands more of these cases in our factories. I am not an expert on placing handicapped workers. I doubt that there are very many such experts in the country. I can merely give you some of my own thoughts on this subject that is becoming increasingly important to the medical profession and the industrial relations director.

It is very encouraging to know that the medical profession is so willing to work with us, as we feel it will be their reports on some of the cases with which we will be confronted that will make it possible for us to place the handicapped worker in the proper jobs. In all phases of employment, plans are necessary, and one of the most important and necessary of these factors is job analysis. Intelligent interviewing, selection, placement and adjustment of war veterans and other workers who might be handicapped, requires that there exist complete current information on the duties, responsibilities, skill, requirements, and physical requirements of the jobs to be filled.

Of prime importance in the employment of handicapped persons is that segment of job analysis which concerns itself with the physical requirements of jobs. Many veterans for instance, who are seekin jobs will be limited by handicaps caused by thei military services in the extent of physical activitie they can perform. The minimum physical require ments of jobs must be ascertained and correctl stated. This step then makes it possible on a scientifi and rational basis to match the physical capabilitie of workers with the physical requirements of jobs

A trend which is of vital importance to the em ployment of veterans can be perceived in the em ployment of handicapped workers. The experience of some outstanding firms during the war and ever before, has shown that there is scarcely a worke no matter what his disability might be, who can b finally classified as unemployable.

There seems to me in cases of handicapped work ers three principles which appear and reappear They are:

(1) There must be a dominating conviction in the minds of both the worker and management tha there is a place for the worker no matter how disabling his handicap if he is able to do some work The emphasis is shifted from what the individua can not do, to what he still can do.

(2) There must be a realistic and liberal appraisa of what physical capacities each individual has which can be utilized in worthwhile work.

(3) There must be accurate information on the physical requirements of each job developed and kept current through job analysis. This willl be an excellent opportunity for time and method study engineers to replan job methods as to handling the work so as to accommodate various physical handi-

*Presented at the Joint Conference on Industrial Health and Safety, New Haven, December 14, 1944*

caps. If the regular worker at the machine or bench can be made to become interested and his sympathy aroused, he can give valuable assistance in making it possible for the handicapped worker to take a proper place on the production line. In other words, it requires cooperation of the employees as well as the good intentions of management to perfect a workable plan. This means that blanket physical requirements are superceded by individual requirements for each job based on a thorough study of jobs in the plant.

Reports show that physically impaired workers employed in factories are just as efficient in the jobs they can do as their unimpaired fellow worker. In fact, experiments have shown that some sightless workers have developed a high sense of touch, which has, in certain assembly jobs, enabled them to excel workers with normal sight.

I feel that the record will show that handicapped workers have a keen appreciation for having been given gainful employment, which causes many of them to become the least troublesome and most loyal worker of a concern.

In a recent survey by the Bureau of Labor Statistics, the general opinion of management in some 300 establishments was that 87 per cent of the 63,382 impaired workers employed in these establishments were reported to be just as efficient as the unimpaired doing similar work. In respect to absenteeism, injury frequency, and labor turnover, the physically impaired were rated as superior to the unimpaired. While 44 per cent of the impaired workers were reported as having an absentee record, no worse than their fellow workers, 49 per cent had better records, 38 per cent were reported as having just as good an accident record, 51 per cent a better record than the workers without disabilities. These figures may not be conclusive, but they are certainly convincing. I wonder if many of us know exactly which job in our company can be held by a person minus an arm or hand? Can we offer our physically disabled soldiers and sailors a job which they can perform safely and at the same time productively, or will our placement be made on the basis of pity or sense of duty? It seems to me we should keep uppermost in our minds:

(1) Can the applicant do the job?

(2) Will he be a hazard to himself or to other workers on the job or to the company? These points must be explained to the applicants also and their reactions to the facts carefully noted.

(3) That the disabled man will not want pity—he will want a job. There is no question but that more time and effort are required to secure effective placement of the handicapped. Effective placement is the key to the successful use of physically handicapped workers in industry. If a handicapped individual is placed on a job where his disability does not effect his performance it follows that for all practical purposes he is not handicapped.

Fair competition has proved that with effective placement the so called physically handicapped can do at least as good a job as can non handicapped workers on the same or similar jobs. For this reason, quite aside from the benefits which society derives from their employment they could be given an opportunity to compete on an equal basis with other workers.

Another class of handicapped persons which I have not mentioned is the mental distressed or cases of neurosis. While we have at the present time a number of this type employed in our factories, we may have a large increase in this class who will be seeking employment from now on. The increase may come from among service men. All of these men should not be looked upon as a bad risk. Many of them without a doubt will make excellent workers. Some of the cases will be no worse, but perhaps less disguised than some persons already in the plant. They will need consideration and orientation.

At this point I would like to parenthetically suggest to the men of the medical profession that they consider taking stock of their equipment and facilities for diagnosing all types of physical disabilities including, especially, those of a mental type. In other words, I am wondering if there will come out of this war new and different physical ailments requiring new and different treatments? And, I am wondering if it will not be necessary for industry to look to the medical profession for guidance on how to best employ this type of person?

In deciding just how a handicapped worker would fit into a particular manufacturing organization, the personnel officer should consider the man's work record before he became disabled rather than wholly by an account of his illness or disability experience. If he has a record of failures, tardiness, absenteeism, illness, and temperamental differences with employers and fellow employees before disability, those things must be considered in placing him. However, if his work record shows that he was a steady reliable worker before disability, it is reason-

able to count on him as still having those assets, once the readjustment is past. Here are some practical suggestions I get from supervisory help:

(1) Do not heap a lot of responsibility on handicapped people—work it in gradually as they grow more used to their work. For instance, it may take a year or two before a discharged soldier has completely recovered from what he has gone through.

(2) If a man is over-sensitive to noise, be careful not to employ him where he will be exposed to sudden, crashing noise. The hum of machinery may not bother him so much, but clanging steel, the noise of riveting, sudden loud bells, or whistles, may be unbearable.

(3) Most men who are nervous do poorly at sedentary work after a very active life in the open; don't expect such a person to sit still at a desk all day long. If you give a man a desk job, plan frequent breaks for him that will give him a little leg stretching exercise.

(4) Do not give him a job as night watchman, in the mistaken but well meaning notion that it will be light work for him. Loneliness and time for thought are just the things that some men may not need. Give him a job where he will be active and pleasantly occupied every minute.

It is my personal belief that the medical profession can and will play an important part in helping to guide management in the employment of mentally and physically handicapped workers. We, in the industrial relations field, must lean heavily on the expert advice of the medical profession in properly placing and training the handicapped worker so that he can with dignity take his rightful place alongside the wage earners of America.

# EXAMINING, PLACING, AND SAFE-GUARDING THE INDUSTRIAL WORKER

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I have been assigned the task of bringing certain subjects to your attention, namely, "Examining, Placing and Safe-guarding the Industrial Worker," which embodies the whole field of industrial medicine other than the care of the occupationally injured. It is possible that the program committee has in mind the postulate that if examining, placing and safe-guarding the industrial worker is practiced to its limit, there will be little occasion for treatment of work produced disability. With this I must agree because it has been proven time and again in innumerable industries.

My object, then, in this communication, is to provoke discussion and even argument within this group relative to the merits of industry availing itself of the services of physicians, beyond its legal obligation, in order to promote the physical welfare of every worker. In other words, the institution of an industrial health service that would include a program to:

1. Conserve the health of employees through physical supervision and education, and

2. Prevent occupational disease and injury by the establishment of adequate control over industrial environment.

Industry is not in the business of practicing medicine nor does it intend to compete with general medical practice. On the other hand, industry is interested in developing its product economically in order to enjoy wide distribution and fair profits. To this end there must be sound management and trained manpower whose physical and mental health is conserved at a high level in order to maintain continuous production and gainful employment. Viewed from this standpoint the industrial health service has a tangible value with relation to production costs. The benefits that can be expected are, (1) that there will be a reduction in accident and occupational disease frequency, (2) a reduction in absenteeism and labor turnover, and (3) a lowering of compensation insurance premiums.

### WORKING ENVIRONMENT

The plant physician can function best if he is regarded as the health officer of the plant respon-

*Presented at the Joint Conference on Industrial Health and Safety, New Haven, December 14, 1944*

ple for plant hygiene. He must familiarize himself ith manufacturing methods, processes, and the aterials used within the plant. The safety en- neer and the industrial hygienist must be his onstant allies if effective control over hazardous perations are to be instituted and maintained. Plant ousekeeping, toilet facilities, drinking and eating cilities, lighting, and heating also come within the ope of the plant physician's responsibilities. aving this knowledge of plant conditions and orking environment he is better equipped to advise nd assist employers in placing men at work and bsequently protecting them against impairment ising out of the working environment. In order at employees may be placed at work for which ey are physically and mentally suited, a knowledge f their physical and mental conditions is also neces- ry; and, in order to maintain and safeguard their ealth, a program of health supervision must be stituted.

HYSICAL SUPERVISION

The key to health supervision of an employed roup is the technique of physical examination and ealth education peculiar to industry. Peculiar, in at the examining physician must be familiar with orking conditions, plant environment, and physical emands of the job if he is to render his greatest rvice to the employee and employer alike. Again eculiar to industry in that the examinee is given the enefit of a health inventory at which time he is cquainted with any significant medical findings. He is counselled at this time by the plant physician egarding the necessity of medical treatment or ollow-up by his personal physician. Physicians now, and those of you interested in health matters now, the benefits that accrue from the prevention f disease, and the discovery with subsequent treat- ent of incipient disease. The life span is prolonged, he economic and social burden is lessened with the esulant improvement in collective and productive apacity.

These advantages can be assured if a program of hysical examinations and consultations is instituted s a regular function of the plant medical service. or purposes of classification these examinations may e systematized according to need as follows:

1. Preplacement examinations, and the
2. Periodic examinations
   a. Transfer or supplemental placement examinations
   b. Re-entrance examinations
   c. Periodic occupational examinations
   d. Requested examination or consultation
   e. Periodic health examination

1. *Pre-Placement Examination:*

Before employment preplacement examinations are given prospective employees before they are assigned to jobs. Generally speaking, this examination has "for its major objective, the assurance of the utmost degree of compatibility between the worker and the job." It has not as its objective the rejection of applicants because of physical defects, for we recognize, beyond any shadow of doubt, that persons with physical disablements do make acceptable and competent employees when placed at jobs in which their deficiencies are not handicaps or at jobs where further aggravation is possible or, again, at jobs which may jeopardize the life and limb of fellow employees.

For all practical purposes the physical examination should be reasonably complete. It should include a brief past medical and occupational history, urinalysis, blood pressure readings, chest x-rays, blood tests, and such other tests or procedures that may be considered necessary or essential. The examination, therefore, must of necessity be adequately thorough to enable the examiner to advise intelligently in placement and yet not be as searching or as time consuming as the clinical examinaiton we are familiar with in general clinical practice. As this is only the beginning of the employee's plant life, the examination must also serve as a source of medical information to guide the doctor in his subsequent efforts in behalf of the workman's health and his continued safe employment.

2. *Periodic Examinations:*

(a) Following employment it may become necessary to transfer employees to jobs whose natures demand physical requirements varying from those originally performed. Physical fitness should again be evaluated prior to the transfer. At this time the examiner can also determine if any harmful effects were suffered as the result of the old job. These *transfer or supplemental placement examinations* need not be as extensive as the pre-employment examinations in the great majority of instances.

(b) The plant physician can avail himself of still another type of periodic examination at the time employees return to work following absence because of illness or injury. Again, the extensiveness of these *re-entrance physical examinations* will depend upon circumstances. They are meant to protect the re-

turning employee against too early resumption of his regular occupation and to effect changes in occupation if indicated.

(c) Theoretically, industrial hygiene and safety methods are effective in safe-guarding employees against potentially harmful conditions, but despite precautions, occupational diseases do occur. So, again, the industrial physician is afforded an opportunity to safeguard the worker by re-examining the exposed group at periodic stated intervals. The purpose of these *periodic occupational examinations* is the early diagnosis of preventable occupational disease and to affect adjustment in occupation if necessary.

(d) Occasionally the plant physician is consulted by employees regarding personal or family sickness. In these instances the physician can render a great service by counselling these individuals regarding the advisability of medical treatment. However, the plant physician fulfills his function when he has arranged for consultation with the family doctor. In the case of newcomers to the community the plant doctor is in a position to introduce them to the local practicing physicians. These *consultations* serve as another opportunity to promote health.

(e) With the program of physical examinations I have outlined, pre-placement, transfer, re-entrance, periodic occupational, the plant physician will have seen, each year, some two-thirds or more of the employed group. How about the remaining one-third? Aren't they ever in need of medical supervision? Shouldn't they be given an opportunity to avail themselves of the benefits of the plant medical service? Some of them will, undoubtedly, be reporting to their personal physicians faithfully once each year or oftener for health inventories or medical supervision but the remaining few should be permitted to present themselves once each year for *periodic physical examination*. At this time, the plant physician will have another opportunity to evaluate physical and mental fitness and counsel the employee regarding his health.

HEALTH EDUCATION

By availing themselves of all these opportunities to consult with employees, the medical department staff is presented with an unique opportunity to disperse health information at the propitious time—that is, at a time when the individual is in the receptive mood for such enlightenment. It is highly effective and can obviously be widespread throughout the plant. Personal instruction of this nature may be supplemented with short health topics in the plant publications, news letters, posters, and the like.

I will conclude my part in today's program by appealing to employers and physicians alike to recognize and respect each others necessity in our present industrial economy. With the advances made in industrial medicine and the ability of industrial physicians to cope with the problem of promoting better health and goodwill within the industrial population, should be recognized by employers. To the physicians I may say that medicine is now firmly entrenched in industry and the specialty of industrial medicine offers opportunities for a satisfactory, useful, and successful medical career.

# PENICILLIN TREATMENT OF NEUROSYPHILIS

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IT IS with some hesitancy and misgiving that I speak on the use of penicillin in the treatment of neurosyphilis. You, as practitioners, will be anxious to obtain practical information for immediate application in your patients. However, experience in the use of penicillin in neurosyphilis is as yet insufficient to permit definite advices. We know the penicillin is good—but our experience with older methods of management of this disease has taught that any new form of treatment should be looked upon conserva-

*From the Boston Psychopathic Hospital, 74 Fenwood Road, Boston, Mass.*

*The penicillin was provided by the Office of Scientific Research and Development from supplies assigned by the Committee on Medical Research for clinical investigations recommended by the Committee on Chemotheapeutics and Other Agents of the National Research Council*

vely until adequate time has passed to determine its mitations. Almost any antisyphilitic treatment, igorously pursued, will give good immediate results. It is the end result which is important. But enicillin has received such wide publicity both in rofessional and the lay press that it is entirely roper for those of us who have worked with the rug to report to the profession what reliable data are vailable and show the general trend of its application. I trust, therefore, that you will understand my caution, conservatism, and lack of detailed recommendations for its use. Many of us regret the publicity which penicillin has received in regard to its beneficial effects in syphilis. We fear that popular demand will result in its improper use. Patients who need no herapy will be treated and others who received inadequate amounts will obtain a false sense of security. Furthermore, the frequent administration of penicillin for various intercurrent infections to patients with unrecognized syphilis or the frequent administration of inadequate courses of penicillin for he disease runs the grave risk of creating a large reservoir of penicillin-resistant cases of syphilis. Yet t is indeed "an ill wind that blows no good." The publicity given to penicillin has helped to bring syphilis more vividly before the public and the profession alike; and if we as a people are willing to face the problem of syphilis as a disease and not see it as a social ignominy, then there is hope for its ultimate control.

The results obtained from the use of penicillin in early syphilis in 1943, were so strikingly good that a study of its effect in late forms of the disease was imperative. Accordingly, the Subcommittee on Venereal Disease of the Committee on Medical Research of the Office of Scientific Research and Development worked out a national program of investigation based on the utilization of well established syphilis clinics throughout the country and designed to conserve the then scarce drug, yet gain the maximum information in the shortest period of time. Under this program cases of neurosyphilis were first treated in late 1943, but it was not until 1944 that the full program got underway. Dr. John Stokes of the University of Pennsylvania gave a preliminary report for the group in June 1944, before the American Medical Association. Due to the cancellation of the American Medical Association Convention, this year's reports will be published from the individual participating clinics. The report of our first year's study was presented last month before the Boston Society of Psychiatry and Neurology.* The data which follows is taken largely from that report.

Neurosyphilis, like syphilis in general, is a disease with many clinical and pathological variations. Its complexity is augmented by the numerous psychiatric symptoms which are prone to occur in patients with and without organic brain disease. These symptoms not only make accurate diagnosis difficult but also interfere with good judgment in the evaluation of response to treatment.

It is our concept that within 2 to 5 years after the initial syphilitic infection the central nervous system will have been invaded by the spirochetes in *all* untreated cases. Fortunately, the defense mechanisms of the central nervous system of approximately 60 per cent of cases are such that the spirochetes do not take hold, are destroyed, or are held in sufficient check so that the symptoms do not develop at any time. The remaining 40 per cent form the great reservoir from which the cases of neurosyphilis ultimately develop. In the overwhelming majority of cases there are no symptoms or physical signs which point accurately to the early central nervous system involvement. The only means of detecting the asymptomatic cases is examination of the spinal fluid, which should be routinely performed in every case of syphilis.

There are many ways of classifying the various types of neurosyphilis, but the simplest and most informative classification is: (1) Syphilitic meningitis, (2) Chronic meningovascular syphilis, and (3) Parenchymatous neurosyphilis. These types frequently merge one into the other and the only reasonably accurate clinical differentiation is based upon response to treatment. However, the time of onset after the primary chancre and the type of spinal fluid abnormalities are helpful.

Experience with old, well established methods of therapy have shown that—(1) Acute syphilitic meningitis may be satisfactorily treated by the vigorous administration of mapharsen and bismuth and careful spinal fluid follow-up to detect a possible relapse; (2) Many cases of chronic syphilitic meningitis and some cases of chronic meningovascular syphilis may be safely treated by mapharsen, bismuth and tryparsamide. However, since these two

*Penicillin Treatment of Neurosyphilis—A preliminary report of 70 cases followed 4-12 months—Augustus S. Rose, M.D., Laurence D. Trevett, M.D., Joseph A. Hindle, M.D., Curtis Prout, M.D., and Harry C. Solomon, M.D. To be published in an early issue of the American Journal of Syphilis, Gonorrhea and Venereal Disease.

forms of the disease frequently cover a smouldering, less evident parenchymal process, it is strongly advisable to administer some form of fever therapy whenever this diagnosis is made and follow it by chemotherapy; (3) Parenchymatous neurosyphilis, with the possible exception of a few cases of tabes dorsalis, requires some form of fever therapy in addition to chemotherapy for its arrest or cure. In general paresis and in primary optic atrophy malaria gives the most satisfactory end result. Artificial fever by the hot box method is preferable for tabes dorsalis. In all types of parenchymatous neurosyphilis, a good end result may be marred by irreparable structural damage to the brain, cord or nerve roots.

Penicillin has now been administered to a sufficiently large number of cases of all types of neurosyphilis to state that it is an effective therapeutic agent for neurosyphilis. As previously indicated, however, it cannot yet be stated how effective it is nor can it be said how long the improvement shown by penicillin-treated patients will last. The present indications are that—(1) It is most effective in acute syphilitis meningitis; (2) It is good in chronic syphilitic meningitis and meningovascular syphilis; (3) It is good in a reasonable percentage of cases of general paresis, optic atrophy and tabes dorsalis, but in these types it is best administered in conjunction with fever therapy.

During the past 14 months the neurosyphilis service of the Boston Psychopathic Hospital has treated 140 cases of symptomatic neurosyphilis. Of these the great majority have been diagnosed general paresis because of their psychiatric symptoms. Since it was evident from the beginning that we would be dealing with late cases and therefore cases with a poor prognosis at best, we did not feel justified in administering an unknown therapeutic agent alone. Accordingly, our program has consisted of a short course, one half the usually prescribed amount, of fever therapy and penicillin, given concurrently or in succession. Some few cases have been given penicillin alone because of various contraindications to fever. In all cases sodium penicillin dissolved in saline was administered intramuscularly for a total dose of 3,000,000 Oxford Units. Until recently all cases were given 50,000 Oxford Units per injection. The interval between injections is varied according to a plan designed to obtain data on the time interval giving best results. A series of cases is being collected with the injections given at—(a) every 4 hours, (b) every 3 hours, (c) every 2 hours, (d) every 1 hour, the latter group having the injections only during the time of their temperature elevation. Recently we have separated another group for study. In this group we have reduced the individual dose from 50,000 to 25,000 Oxford Units and give it at the same intervals day and night for the total of 3,000,000 units. All cases receive no other antisyphilitc therapy than the one half course of fever plus the penicillin. Some few cases have been given a second and third course of penicillin if clinical judgment demanded it. Fever therapy is not repeated.

The clinical results of this study show that of 36 cases of reasonably early general paresis 24 are improved, 11 have shown no change, and 1 is worse. On the other hand, 13 cases of long standing general paresis which maintained positive spinal fluids and had not improved in spite of other therapy are now considered as—1 improved, 10 no change and 2 worse.

The cases of tabes dorsalis, as would be expected, have shown no dramatic change. But the results obtained in 6 cases of primary optic atrophy are striking. Five of the 6 have obtained an apparent arrest in visual loss. The other case has shown progression. This is notable for no form of therapy has ever shown such a high percentage of arrest of visual loss. This result has been obtained in other participating clinics.

Possibly more important than the clinical results at this stage of follow-up are the spinal fluid results. These show two trends—(1) An immediate response of an increase in the number of cells and of total protein together with a temporary intensification of symptoms, and (2) A gradual reduction in cells and protein to normal followed in weeks or months by a decrease in the intensity of the Wasserman reaction.

The first of these changes occurs only in previously untreated cases and may be considered a modified therapeutic shock or Herxheimer Reaction. Such reactions occur only following the administration of potent antisyphilitic substances and so may be accepted as evidence of the spirochetocidal potency of penicillin.

The second type of spinal fluid change is more familiar for it is what has been observed following the administration of malaria therapy. A comparison of the spinal fluid of the penicillin-treated cases with comparable cases treated by the older methods shows an entirely comparable trend. But, unfortunately, we cannot report that the effect on the spinal fluid by penicillin treatment is better. It is not better, although it does compare favorably.

Since syphilitic meningitis is rarely accompanied by psychiatric symptoms, we have only one case in our series at the Boston Psycopathic Hospital. This case, while under treatment, exhibited rapid reduction in papilledema and disappearance of headache and confirms the result obtained by others who have treated a fairly large series of this type of neurosyphilis.

SUMMARY AND CONCLUSION

Long experience has shown that neurosyphilis, even though asymptomatic, is an extremely serious and potentially fatal disease. Prior to penicillin, the results of treatment were good if managed vigorously by the prompt use of fever therapy and chemotherapy. The best results were obtained in syphilitic meningitis, the poorest results in general paresis and primary optic atrophy.

After one year's experience with penicillin it may be stated that penicillin is an active therapeutic agent in all forms of neurosyphilis, but the degree of effectiveness has not yet been determined. The best results are obtained in syphilitic meningitis. A small series of cases of primary optic atrophy have shown a surprisingly good result. All forms of parenchymatous neurosyphilis apparently need fever therapy as well as penicillin. Penicillin is an agent which acts directly upon the invading organisms and therefore can be useful only in cases in which there is evidence of spirochetal activity.

The time has not arrived to recommend the use of penicillin in the treatment of neurosyphilis. There is every hope that within the next few years sufficient data will have been obtained so that regimes of treatment can be advised and the management of neurosyphilis can be safely administered by the general practitioner.

# THE SAFETY GLASS PROGRAM

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A WELL KNOWN philanthropist once said "the most trouble I have gotten into has always come from doing someone a favor." This, in my opinion, constitutes the greatest factor of experience I have gained from the Safety Glass Program. Certainly this program is an idealistic one, but the administration of such a program is beset by pitfalls and difficulties, some of which will be defined.

The ordinary pair of glasses is said to give 85 per cent protection to the eyes regardless of the fact that they are made only of plain optical glass. This fact is often proved by the presence of multiple specks or chips on the ordinary glasses after use in a factory for a limited time. Molders and metal workers have even had celluloid frames burned off their faces without injury to the eyes. The average steel chip spauled from a hand hammer blow does not ordinarily perforate optical glass. In the experimental metallurgical laboratory, we have seen chips drive through 1/16 inch leather aprons, but never break optical glass. Thus arises the question of whether or not a heavy, annealed or case hardened glass is necessary, granted that we realize ordinary glass gives such a great amount of protection.

The program of fitting safety glasses was stimulated in this area by several cases seen in the factories in which the ordinary semi-fitted shatter-proof lens was given to the worker by the nurse in the factory with no attempt made whatsoever to match the pupillary distance with the optical centers of the glasses. These workers complained bitterly of headaches after doing certain close work over a long period of time. It has been shown by the Connecticut Commission of Opticians that the extra heavy plated lens is apt to have a peripheral deviation which, when improperly fitted, will subject the patient to a definite prismatic effect.

The administration of this program requires just as much, if not more, energy on the part of the doctor as his ordinary practice. The fitting of the glasses is a greater problem at times than the average office case because many times you have an ignorant individual who has been sent to your office because the "foreman said so" and "he don't believe in it, anyway." The fitting cannot be trusted to untrained

assistants any more than the fitting of glasses in your regular practice, whether it is done by yourself or your optician. The practice of the optical companies in giving lay people a couple of weeks training and allowing them to do this type of work should be definitely discouraged. One factory assigned a so-called Safety Man to do the fitting and adjustment of glasses. Here the intent was good, but the result poor—so poor that this office asked that the procedure be stopped rather than let our work go out and be manhandled. The Connecticut Commission of Opticians cooperated quite enthusiastically in this action, independently of us.

After the Safety Glass Program was started in one factory, the program went completely bad due simply to the fact that the fitting of the glasses was done by a willing but poorly trained nurse in the factory hospital. She was unable to cope with the problems and the psychology of fitting glasses and hence the program got off to a bad start. It is interesting to note in this same ball bearing factory that, as soon as the trend of employment went from teen age and young individuals under thirty to women and men over thirty, by courtesy of Brigadier General Hershey, the incidents of simple eye injuries, of the average of which only 65 per cent were not considered doctor cases and were treated by the hospital nurse, dropped approximately 95 per cent, regardless of the Safety Glass Program. It is obvious the factor of carelessness is incident with the age group; also, older workers are more apt to have glasses on than younger ones. Again, women, as a rule, are more careful workers than men.

The Safety Glass Program is truly an idealistic and fine program, but its administration is much harder to carry out successfully than the simple refracting and testing of eyes in the average doctor's office. Frankly speaking, to us it is a headache. One factory inaugurated the program under the direction of the insurance doctor stationed at the factory. The first step was a meeting of the foremen and a frank discussion of eye hazards. This meeting was stimulated by the loss of vision of three eyes from intraocular steel. In all three cases, no glasses were worn because they were such occupations in the factory as ordinarily did not stimulate eye protection arrangements. A motion picture was shown to the foremen illustrating how eyes were injured. Then, the motion picture was shown to other employees in various departments where eye hazards were heavy. The next step was the referral of the employees to the refractionist for testing of eyes and fitting of glasses. One factory made the bad mistake of giving the glasses to some employees and not to others. Some employees in other factories came to the office with the attitude that the factory should pay for the glasses, and as soon as they found out they had to assume the cost, they never returned. A definite procedure should be adopted by each factory and the worker fully advised of it before being sent for examination. This would help avoid confusion and help dispel the attitude too many have that either the factory or the doctor is trying to "put something over" on them.

The administration of the program needs many improvements yet before it will be satisfactory to all concerned. To the ophthalmologist it does, in my opinion, offer a key to the solution of the so-called "glasses problem" found by men examining eyes, especially in the smaller communities. The price of glasses is so often considered in excess of what it should be. A good, thorough refraction takes a minimum of one half hour and with drops and prove-ups later, it is obvious that good work takes time. If the eye man asks an adequate fee for his work, the sum total of fee and the cost of the glasses is often prohibitive for many people. They go to the dime store, and later a certain number to the State Board of Education of the Blind. The resolution adopted by the Section of Ophthalmology of the American Medical Association, June 1924, makes it contrary to all standards of medical ethics to accept commissions or considerations directly or indirectly from opticians, optical houses, etc., from the sale of glasses. Therefore, to keep the sum total of the refraction fee and cost of glasses down for the benefit of the patient, the ophthalmologist must either reduce his fee and take a profit on the glasses, or hold his fee to a justifiable figure and reduce the price of the glasses. Neither of these procedures is favorably looked upon, but situations sometimes force their consideration, unfortunately.

The Safety Glass Program allows a man to do a better job and to charge a justifiable fee for it. The patient gets his glasses at a reasonable price, with the company contributing a certain percentage of the cost. He also gets the benefit of a thorough eye checkup, plus the protection and usefulness of his glasses. The company gets better work because of better vision, a reduction in the accident rate, a good visual record of each employee examined and a possible classification of the employee in regard to the job he can do most efficiently.

The relationship of doctor to factory management

nust become closer in the administration of this program if it is to be successful because he will earn some of the difficulties they have with vision problems and they will realize some of his in coping with these problems. Most personnel men, when they re first exposed to the program, expect a simple procedure with no complaints, but after a few weeks hey realize the limitations and most of them feel hat the program is about the same as the fitting of afety shoes, safety aprons, guards on machines, etc.

Another thing management may not understand s the difficulty of dealing with human reactions, especially with such a type of crutch as the glass represents. The psychological aspect of the wearing of glasses is often entirely overlooked or misunderstood. The layman expects a pair of glasses to be ordered and held on his face with absolute certainty nd accuracy and complete disregard, in most cases, for the patient's individual idiosyncrasies or reactions. There again, the need for replacements or small changes that must be made in glasses, and which have been for years accepted as part of the business, is not understood by the factory personnel managers. In conducting such a program as this, these minor replacements, adjustments of glasses, lenses, frames, etc., to match the person's reactions, and, in many cases, to allow for his ignorance, are not anticipated. When such extra cost is presented to management they are at times indignant. In the retail sale of glasses this extra overhead is anticipated and allowances made in the margin of profit to take care of replacements which we know must inevitably be done. If the factory management does not understand this point thoroughly, there is a great deal of room for personal and personnel difficulties.

Many of the objections to safety glasses are on the basis of appearance. For the most part, safety glasses must be unusual in appearance because of the requirements of the National Safety Council for protection. The patient must be made to understand that the glass is heavy and consequently harder to wear and does not have the appearance of ordinary glass. If the frames are also unusual in appearance, they may be strenuously objected to. In the administration of the Safety Glass Program, the element of human vanity, especially among women workers, must be given consideration. In other words, if the glasses do not look well, people will not wear them, protection or no.

The psychology of getting something for less than what it costs in the outside market is not understood by the average factory worker; hence, most of them approach the safety glass with trepidation, simply because it doesn't cost as much as they pay for glasses in the store. Our so-called commercial educators have taught the people to think that "if it is cheap it must not be any good," and this idea of a cheaper pair of glasses immediately strikes the responding note of "they must not be any good."

At the present time, most factories in this defense area, through experience, have given up the idea of furnishing glasses free of cost to their employees. They have also given up the idea of requiring them to wear the safety glasses. In other words, you can lead a horse to water, but you can't make him drink.

There is still much to be done to work out a completely satisfactory program. The National Society for the Prevention of Blindness has a manual on conservation and utilization of eyesight in industry which has many excellent suggestions as to methods of improving the program. The greatest difficulty is the lack of understanding by factory management, and more so by the worker, of what results are possible to their mutual benefit. We are learning by experience and the general public is also learning what can be done for them. Yet, of the several thousand pairs of safety glasses processed in this area in the last year, we know that many of them hang at the side of the machine or rest peacefully in the bottom of the drawer at home.

# AN EVALUATION OF THE PREMARITAL EXAMINATION LAW IN CONNECTICUT

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CONNECTICUT was the first state to pass a comprehensive law pertaining to premarital examinations for the discovery of syphilis. This law became effective on January 1, 1936, so that at the time of this study six years have passed in which to test its results. Since the passage of this law some thirty states have also incorporated laws to detect venereal disease. The history and development of such premarital legislation in the country as a whole was studied with particular emphasis on the nearby states of Massachusetts, New Jersey, New York, and Rhode Island. The enactment of such legislation was mainly due to the activities of interested lay groups in the respective states.

This study was undertaken in an attempt to see whether or not a lessening of the effects of syphilis had occurred since the introduction of the law in Connecticut, with findings which might reasonably be attributed to the operation of the law. This legislation may not be as important in curtailing syphilis as it is a case finding agency. This fact alone would justify the trouble and expense of its operation.

Hospital records, a potential source of data, have not been widely explored in this field. Where data from routine blood tests, given upon admission for all hospital services, including obstetrical and gynecological cases, are available, these data may be used to study the effect of premarital legislation. The number of cases is small and cannot supply a final answer with respect to evaluation. Many of the observations may not actually be due to the influence of the blood test law alone. Even so the methodology may be useful and suggestive to other groups desiring to evaluate the effect of premarital laws.

Two main lines of investigation were used in th present study.

1. Permission was secured to utilize records o maternity cases in a large urban Connecticut hos pital where routine blood tests are taken. Each nam and date of marriage in the case history was checke with the marriage lists. The purpose here was t enable a comparison of groups married before an after 1936 with respect to blood test and outcom of delivery.

2. An analysis of stillbirths in Connecticut an trends of neonatal data were made. Neonatal mortality, especially for the first week of life, is a rough index of maternal syphilitic infection, and therefor valuable as an aid in this analysis. Neonatal mortality from congenital syphilis, as well as stillbirths and stillbirth rates from congenital syphilis were also chosen as indices of this infection.

The study group was made up of the obstetrical cases recorded from 1933 through 1940 in this hospital. Comparisons were made of blood tests and conditions of children at birth to mothers who were married before the law became effective, as contrasted with mothers married after the operation of the law.

The numbers involved in the hospital study are relatively small, yet suggestive results based on statistically significant figures were obtained.

The results of blood tests were found for a very large percentage of all mothers delivered in the hospital where the study took place. Out of 3,700 mothers 3,562 or 96.3 per cent were located as to result of blood test.

The greatest number of positive tests occurred in age groups 20-29 years, also the highest number of births. Mothers married before premarital laws showed 14.4 per thousand with positive tests. Those married after its effect recorded only 5.7 per thousand positive.

*A summary of a dissertation presented for the M.P.H. degree, Yale University, 1943*

Analyses made on a color basis proved that only bout 10 per cent in the study were non white, so hat further breakdowns by color were excluded.

The trend of syphilis and positive serology for the ntire period 1933-1940 was another important fac- r to consider. Although information on this point scarce, useful estimates can be made by comparing stimated rates for the hospital group, which would ave been noted if the earlier rates had continued, vith observed rates where mothers were actually ubjected to the laws. The positive serology rates or the years 1933-1940 revealed that if the trend or 1933-1940 had continued the rate would have een about six cases of syphilis per 1,000 births. This gure is almost twice that actually recorded by the udy.

In analyzing the condition of the child at birth avorable effects were noted after the date when remarital legislation was put into operation. Normal abies increased; premature, stillborn and malformed abies and infant deaths decreased.

The trend for the eight-year period 1933-1940 mphasized such findings in the condition of chil- ren. The rate for normal babies increased after 936. The rates for stillborn babies and infant deaths ad decreased after this date. Premature and mal- ormed children were not analyzed in such trends as these conditions were not felt to be typical of the study group.

In working out the probability of rates for normal, stillborn and dead babies, had earlier trends continued, the rate for normal babies would have been 94.0 per 1,000 children. After such legislation the rate actually was 96.2. Had the trend of stillbirths continued as before the law the rate would have shown 2.0 per 1,000 live births. The hospital group of mothers subjected to the law showed a rate of 1.5 per 1,000 live births. The rate for deaths under one year was estimated as 1.0 per 1,000 live births in the absence of premarital laws, in contrast to the rate of .8 in the hospital group after 1936.

Mortality rates have steadily been decreasing in the period 1930 through 1940. Connecticut showed the lowest rate of all the test states for neonatal mortality, as well as for deaths from syphilis under one year and stillbirth rates. Connecticut had no deaths from syphilis under one year in 1938, 1939 and 1940.

While no attempt has been made to present incontrovertible evidence for the value of the premarital law, the data included in this study seem to indicate more improvement than might have been expected without the additional impetus of such legislation. These criteria are suggested for use in more extensive study and evaluation.

# MEDICAL EDUCATION — OLD PURPOSES AND NEW METHODS

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FOR THE privilege of addressing this convocation, inaugurating another link in the cordial bond that has always existed between Brown University and the medical profession, the reader is deeply indebted to the University officers and his medical colleagues in Providence. Long interested in the history of my calling and in the education of the doctor, I find an opportunity in this occasion to set down a few thoughts that seem pertinent to the subject, largely based on the experiences of my own education, without attempting, if indeed I were capable, to quiet the turbulent waters whirlpooling around the problem of medical education in general. If I only succeed in breaking the shore-ice, perhaps we will have a clearer view of the goal, the doctor fully equipped and ready to serve his fellow man. The objective of medical education is the same today as always; only the methods of reaching the academic end of the journey, rightfully called "commencement," have changed with the passing years. Brown University once travelled this road; some of the wayfarers set down an account of what befell them and we may profitably stop to review briefly their enlightened experience.

In the early Nineteenth Century, Brown University, as was the custom of the time, bestowed upon its medical worthies, most of whom had seen the inside of her academic halls, but had of course never attended a medical school, an honorary degree of Doctor of Medicine. Harvard University followed the same practice. For an earned degree in medicine at the Harvard Medical School, the procedure was to grant a degree of Bachelor of Medicine at the time of graduation and follow this, seven years later and after another examination, with the degree of M.D. In the intervening years the doctor assisted one of the older men or, if bold enough, struck out for himself. In 1811, however, came a decided change in Harvard University policy for in that year the granting of the degree of M.B. was abolished and all medical graduates from then on received the degree of M.D. To the holder of the M.B., graduated in the previous seven years, also went the M.D., an interesting reshuffle bringing all the medical graduates up to an even level. If Brown University was to give a degree of M.D. on graduation, Harvard University could not lag behind; or was it Harvard who stimulated Brown to start their medical school the same year?

## THE INFLUENCE OF BENJAMIN WATERHOUSE

The answer is not clear, but a sound reason for the beginning of the Brown University Medical School lies in the growing realization on the part of the younger men in medicine throughout the colonies, many of them by this time trained abroad, that adequate clinical facilities were an essential part of a complete course of medical instruction. The Harvard Medical School, situated in Cambridge in 1811, was greatly influenced by Benjamin Waterhouse, who only had to walk a few steps across the green from his house to the lecture hall. He bitterly opposed moving the school to Boston, to be near the then contemplated Massachusetts General Hospital, a suggestion that had come from two young firebrands in medicine, John Collins Warren and James Jackson. Waterhouse, after endeavoring to establish a rival school which had an ephemeral existence, finally was forced to resign from the Harvard Medical School faculty in 1812. The attack of these spirited young men against the limitation of medical instruction to didactic lectures, quite possibly stirred the imagination of Solomon Drowne in Providence, a wise practicing physician, long a member of the Board of Fellows of Brown University. It was he, you will recall, who suggested to President Messer the idea of a medical school at Brown and promoted its establishment in 1811, the very year that the

*Reprinted by permission from the Rhode Island Medical Journal*
*Read at the Medical Convocation, Brown University, Providence, R. I., August 9, 1944*

Harvard Medical School was shaking with faculty dissension. The two physicians who joined Drowne in beginning the school at Brown, William Ingalls and William Corlis Bowen, were also practitioners of medicine, thus reinforcing our surmise that the ferment in Boston and Cambridge, based on the desire to study disease at the bedside, was also at work in Providence.

Although Professor Drowne's prescriptions seem to have been mainly composed of "butter-nut pills, decoction of mallows and pussy-willow tea," he did care for the sick in addition to giving his botanical lectures and without doubt realized the importance of teaching his students the art of practice, as well as instructing them in the intricacies of raising herbs on the slopes of Mount Hygeia. Ingalls, moreover, was a surgeon actively engaged in his profession, as well as a teacher of anatomy, and Bowen, the chemist, continued in practice, as had his long line of outstanding medical ancestors, who, as Goddard quaintly remarks, "Signalized in the medical history of Rhode Island, by no ordinary attainments in professional science, and by a diligently, successful and honorable practice."[1] Bowen died, tragically, of chlorine poisoning in his thirtieth year, while experimenting with this drug as a bleaching agent, just prior to the establishment of that industry in Providence. Coming in 1815, only four years after the infant school of medicine was established, this must have been a hard blow, for Bowen gave every promise of a brilliant career. The School, however, survived with vigor, stimulated greatly a few years later by Commodore Perry's surgeon's mate, Usher Parsons.

Of the ninety odd graduates of the Brown University Medical School, a few attained places of high distinction in the profession: Jerome V. C. Smith as a medical editor; Alden March in medical education and Elisha Bartlett, that peripatetic professor and Osler's "Rhode Island Philosopher," who enlightened the students in no less than nine medical schools of his day.

### BROWN MEDICAL SCHOOL CLOSED IN 1826

When Dr. Messer resigned as President of Brown University in 1826, the Reverend Francis Wayland, Jr., of Boston, became President. He was a man of pronounced convictions and, unfortunately for medical education, one of his most unwavering beliefs was that all professors in the University should live in residence, devoting their entire time to work in their respective departments, as part of an academic family. President Wayland does not seem to have visualized the advantages of "combining academic drill with the invigorating breezes from the outside world of public and professional life."[2] A situation impossible of profitable solution was at once provoked in the Medical School and its doors were closed the same year. As Charles W. Parsons puts it: "In drawing the reins up so suddenly and turning so sharp a corner, it was not strange that something should be jolted out, and the Medical School had the loosest hold."[3] The names of the professors continued in the catalogue for a few years but apparently instruction was not given and the School became a thing of the past, much to the regret no doubt of the local physicians, and indeed to the former teachers who had served it so efficiently. The School in its fifteen years of existence had established a sound reputation and we can look back now with pride at an outstanding effort in medical education by Brown University in an age when the doctor-student apprentice system was slowly evolving into a more formal type of teaching doctors the art and science of their vocation.

Although those "invigorating breezes from the outside world" were largely shut out in 1826, as far as medicine was concerned, by President Wayland's action, the University did not entirely give up its neighborly relations with the doctors and the community they served. Providence was too closely knit for that. After the establishment of the Rhode Island Medical Society in 1812, Brown honored that Society by giving the honorary degree of M.D. to many of its Presidents, but this pleasant custom seems to have been abandoned by 1828. Of more importance to us today was the Brown University Medical Association, consisting of professors, students and resident physicians, founded in 1811 and surviving until 1825. Weekly meetings were held and a library was formed for the use of all. In this association was the germ of an idea, now, in 1944, worthy of being recultivated and made productive.

### UNIVERSITY RELATIONS WITH MEDICINE

In part, at least, Brown University never quite cloistered itself from the whole community. In the nineteenth century, lectures on natural philosophy and chemistry were often arranged for the public and the idea of "university extension" was given a practical outlet from time to time. For medicine, however, the stream seems to have run nearly dry, although a Brown University Medical Association may have continued to exist throughout the century

after the Medical School was closed. At least there was a Medical Association alive in 1896, for it was duly recognized on that date by Dr. W. W. Keen, one of Brown's most distinguished graduates. Keen's paper, on the requirement for a professional career in medicine,[4] written for the 'Brown University Magazine,' touched, among other things, upon the value of studies in the humanities under inspiring teachers. A student, he wrote, "will be none the worse a doctor if he can read an ode of Horace, or a page of Homer, nor will he handle the scalpel any less deftly if he knows Shakespeare by heart or owns a well-thumbed Goethe." Coming from one of the most active surgeons of his day, always in the forefront of his profession both in the technique of surgery and in the advancement of knowledge by experimentation, later called 'research,' Keen's words echo my thoughts today. I do not mean, of course, that one must be versed exclusively in the humanities to qualify as a great, or even, a sound doctor. Good moral character, good manners, perserverence and studiousness are, as always, the four characteristics necessary to make a successful physician. The master word, as Osler pointed out, is "work" and doctors, who rarely appear in the bankruptcy courts, know the truth of Emerson's comforting statement: "Make yourself necessary to the world, and mankind will give you bread." Sir James Paget, in a famous paper on, "What Becomes of Medical Students," found that sixty per cent achieved success, in varying degrees, eighteen per cent had "very limited success" and twenty-two per cent died or left the profession. Keen, who falls high in Paget's scale, felt that the place a doctor takes among his fellows, both of his own calling and in the entire community, depended not a little, "on his ability to set forth his ideas clearly, logically, forcibly." In this, Keen's training in the humanities at Brown University was, as he states, invaluable to him in later life. Others, besides Keen, who have risen to heights, have expressed their indebtedness to their undergraduate instruction and I believe the inspiration behind this convocation, bringing together the academic faculty of a great University, and the "outside breeze" of men actively engaged in the practice of medicine is essentially based on a desire to develop a modernized "angelical conjunction," between *magister* and *medicus*.

### DUTIES OF UNIVERSITY TO PROFESSION

The duties of the University to the profession lie in many fields: the undergraduate, aspiring to become a student of medicine; the recent graduate, earning his laurels in hospital or clinic; the practitioner, striving to cope with the rushing tide of rapidly advancing medicine in chemotherapy, biotherapy or surgery; the weary doctor home from the beaches of Salerno and Normandy or from the fever-infested lands of the South Pacific and the advanced student, who wishes to search out the estrogenic or gonadotrophic hormones or explore the possible germicidal properties of cabbage juice. To any of these the University can offer a rich store of science and culture.

The pre-medical student may with profit, even in his earliest days, "walk the wards," following in the footsteps of his predecessors who learned so much by observing how the doctor approaches the patient and, even more important, how he leaves the patient. To Osler, in this country, we owe a debt to his insistence on bedside teaching, that osmotic process, so fundamental to the education of the doctor. I am sure I absorbed more medicine by contact with Osler, Sherrington, Cushing and Head than from all my formal courses in the medical school combined. Of some of them, no doubt painfully put together by conscientious men, I remember nothing, but I have little doubt that settled somewhere in my subconsciousness the essence of their devoted labors still resides. The effect may well be greater than we now realize for every impact of mind on mind affects our being. If Brown, however, will bring in the "outside breeze" from the hospitals and clinics and let it blow on its medically-minded undergraduates, the program you have in mind will be fully justified. There is no substitute for Mark Hopkins on the other end of the log.

Medicine, however, has long outgrown a Hopkins of any type. The ever broadening horizon is now beyond the sight of one individual. Specialism has become a necessity and the man who could write a text, with considerable completeness, even in his own field of endeavour, is rapidly vanishing from the medical world. Medicine must come, particularly to the recent graduate, by piecemeal, a nubbin here, a jot there. The intern or resident in any one of your many hospitals in Providence and its vicinity, could profit from the academic atmosphere, if a little more found its way into the wards, the laboratory and the deadhouse. If his body is not overworked, as so frequently becomes a necessity in a war-time environment, his mind is still plastic. Feed him, indeed, with a little of the basic diet of biology, physiology and chemistry and he will thrive, possibly beyond expectation.

### PROBLEM OF RETURNING SOLDIER-DOCTORS

For the returning soldier-doctors, the diet must be more carefully ground. They are a sober, often badly shaken group. Many have seen God in their daily lives and have been deeply stirred by His proximity. For them, we need special handling, each man as a unit, and the Dean's pia mater may well be stretched to the near breaking point, before an individual problem is fully resolved. I hope we can avoid more "indoctrination," "refresher courses" and the grinding process of regimentation, so foreign to American life. A year of freedom, without restriction, in the University group, might be the best answer to the post-war educational problem of the returned soldiers. These men, above all, would profit by nourishment with sound scholarship of any type, particularly if there were added an ample sprinkling of the arts, to what, of necessity, they must acquire of the sciences.

### THE OPPORTUNITY IS AT HAND

The practitioner, ever stretching his waking hours to fill the demands for his services, finds his few leisure moments unevenly spaced and often frequently interrupted. For him, I can only advise an occasional lecture, preferably by a visitor, sponsored by the University. If possible, have the distinguished guest 'in residence' for a few days, informally making the hospital rounds and dining with the doctors, students and interns. How much that is most influential in our lives, comes incidentally, as we move in and out among our fellow-men. Not all the principles on which are based our Hippocratic standards have come from the near side of the lecturer's desk. If the art of life, as Lawrence Lowell puts it, "lies largely in distinguishing the eddy from the stream,"[5] was not that knowledge largely acquired in each of us by absorption, through our personal relations with the men of the preceding generation?

In establishing in 1944 a Department of Medical Sciences, Brown University is reviving, within her halls, a tradition of long and honorable standing. The opportunity is at hand as never before, to knit together the academic departments, particularly those devoted to teaching and research in science, together with her laboratories and libraries, with her pre-medical students and the junior and senior members of the medical profession in Providence. The University doors are again open to student, intern, resident, practitioner and hospital personnel. May both parties gain profit from such a conjunction of spirits, each finding in the other a sense of time and place, fitting to the occasion.

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*Owned and Published Monthly by The Connecticut State Medical Society*



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# EDITORIALS

## The Wagner Bill — 1945
## S. 1050

Senator Wagner and his echoes, Senator Murray and Representative Dingell, have introduced the 1945 version of the Wagner Social Security Bill before the Congress of the United States. It appears that Senator Wagner is impressed by the favorable response from medicine, hospital experts and other important professional groups to the Hill-Burton Bill which would provide Federal funds to study health needs in the several states and funds to subsidize hospital, laboratory and clinic construction where needed in the opinion of the states. All of the purposes and most of the provisions of the Burton Bill are included in the new Wagner Bill, S. 1050, entitled "Social Security Amendments of 1945."

It is an old political trick that Senator Wagner is employing. Combining desirable and favored legislation with other measures less desirable and easy to take is a time honored device and is sometimes successful. In this instance people will be asked to take the undesirable and revolutionary Wagner health insurance proposals if they wish to get the hospital subsidies that have been favored. There are many other provisions in the bill also. Broadly speaking it would establish a national social insurance system consisting of prepaid personal health service; unemployment and temporary disability insurance benefits up to $30 a week on a uniform national basis; and retirement, survivors and total disability insurance with more liberal benefits than in present law. It would provide grants to states for the expansion of health services, maternity and child welfare services and would extend the coverage of the social insurance system to an estimated 15,000,000 additional workers—farm and domestic workers, employees of non profit institutions, independent farmers, professional persons and small business men.

The *New York Times*, previously largely in favor of Senator Wagner's proposals, has this to say: "It is a central aim of social progress to mitigate the

hazards of unemployment, need, sickness, disability and old age for the individual. Every step is to be welcomed by which this can be done without itself introducing equal or greater hazards. This indicates the questions to be asked of a proposal like the Wagner-Murray-Dingell bill. Will it provide relief where it is needed without producing it where it is not needed? Will it mitigate the penalties for failure or misfortune without weakening the incentives to production and success? Will it provide aid to individuals without making them politically dependent and without dangerously extending the power of the central Government?

"Under the bill as it stands it is more than doubtful whether these questions can be answered satisfactorily. Even under the present social security program we face problems for which we have not yet produced adequate answers. Yet under the new bill vast new programs would be undertaken and existing programs would be tremendously 'liberalized.' . . . For example, a schedule is provided under which a worker making when employed an average of $40 a week could draw as high as $30 a week unemployment benefit. Would not such payments tempt the creation of the very unemployment they are designed to meet? If a man who can get $40 a week for working can draw $30 a week for not working, then so long as he is entitled to draw benefits he is in effect working for only $10 a week; that is the way many will naturally look at the matter when they are asked to take a job, or when they consider giving themselves a vacation at government expense."

An 8 per cent tax would be levied to finance this new cradle-to-the-grave security service. Four per cent would fall against the employer, a similar amount against the worker. Senator Wagner's Bill of last year was less inclusive than the present but a 12 per cent tax was called for in the previous measure. It seems fairly obvious to Washington observers that the clique endeavoring to extend social security and create national health insurance know that if adequate direct taxation is written into the measure it will defeat it and so taxation only partially capable of supporting the great expenditures involved is provided in the bill itself and the deficit financing will be undertaken through the maintenance of present high income surtax rates.

Discussing the financing, the *Times* says, "The tremendous financial commitment involved in the Wagner-Murray-Dingell Bill ought to involve the most careful study, even in a period when the budget is balanced and on a relatively manageable level. To undertake it lightly at the present time, when the budget is already unbalanced to an unparalleled extent by the war, and when the path back to balance and manageability is already far from clear, would be an assumption of obligations without considering how they are to be paid."

To the people at large the financial considerations are far more important than any opinion on health insurance that the medical profession might hold, but it is still national health insurance or the provision of medical care by Government. Although it has been stated to the contrary, it is not clear how a sick person is to have the services of the physician of his own choice if that physician does not elect to participate in the system and accept recompense set arbitrarily for him by the Government agency.

It has been forecast that the Bill will have a stiff fight in the Congress and it may be 1946 before serious consideration is given to it.

## An Open Letter to Our Medical Officers

From time to time the JOURNAL has published letters from our members in service which have contained interesting and pertinent comment upon medical affairs. This has been most helpful and we have been impressed with the things which you men are thinking about. An appeal is now made in order that we may have more comment of this kind and publish more of such expression from the military physician's viewpoint. It would appear to be useful to keep the source of all statements confidential and letters to the JOURNAL or to the executive secretary need not be signed unless required by military regulations: Names will not be published unless desired.

Those of us who have remained at home during this war are deeply interested in what members of the Society who are serving in the Army-Navy think about a lot of things. Will you, therefore, write a letter to the secretary's office and express any ideas which you wish to? Particularly we would like your comment on group practice—do you think it would be a good idea in Connecticut and would you be interested in becoming a part of the group? There seems to be some commotion about "open staffs" in hospitals; that is, permitting any physician to do anything in any hospital. Do you think that is a good idea and would you advocate it? Are you interested in full time clinical work, such as a full time staff around a community hospital where all members of the staff are paid salaries and have their

offices in the hospital? Do you think there is going to be a further trend toward specialization after the war; if you are not trained in a specialty, do you contemplate taking that training and establishing yourself ultimately in special practice? Are you interested in working for the government after you are out of the service and do you think that compulsory health insurance will be a good or bad thing for the people and the profession?

These subjects are suggested to you not as a questionnaire and you will probably think of many other things that you would like to write about and upon which we would like to have your opinions. Have you been busy in the service or have you not? Just plain gripe if you want to, but do take pen in hand.

The Editors

## Occupational Health

*The following comment upon occupational health was prepared at the request of the* JOURNAL *by Dr. Raymond Hussey, Dean of the School of Occupational Health, Wayne University, Detroit. Dr. Hussey was formerly a member of the teaching staff of the Yale University School of Medicine.*

Occupational health programs deal with physician-employee relations. The physician in charge of an occupational health program serves as a liaison officer in human relations to management and the family physician.

The physician-employee relation begins with the proper placement of an individual in a job for which he is fitted and a job which fits the employee. This activity is known as selective placement which involves a knowledge on the part of the physician of technological and physical requirements of particular jobs and a health examination from the point of view of the prospective employee's physical, mental, and emotional pattern, i.e., psychosomatic health evaluation. A follow-up of an individual after placement to determine job adjustment completes the employment phase of the plant physician's activity. This procedure involves coordination with the work of interviewers, supervisors, and foremen.

In addition to the preplacement psychosomatic examination and a knowledge of job requirements, it is necessary for the physician to know the environmental working conditions. This is accomplished by information about the raw materials, operations, and processes connected with the job, information regarding the atmosphere with reference to contamination, as well as a knowledge of the various substances with which the individual comes in contact. This knowledge furnishes the basis for appraisal of environmental potential health hazards. Information regarding the environmental appraisal requires an engineer, so it is necessary for the physician to coordinate his work with the engineer who is responsible for the plant environmental health inventory. This field of engineering has been artificially divided between the fields of sanitation, hygiene and safety. At the present time no one individual can cover these three fields since the requirements in one instance need an individual with chemical training and in another instance, mechanical training. The integration of this type of engineering assistance has been needed for a long time and should be developed along the lines that have met success in integrating into Medicine such subjects as chemistry, physics, and bacteriology in the study of the etiology and control of disease. It is suggested that these complimentary activities of medicine and engineering be designated Occupational Preventive Medicine and Occupational Preventive Engineering.

Occupational Preventive Medicine includes, in addition to psychosomatic health appraisal to determine occupational fitness, the etiology of health, health education, personal hygiene, occupational hygiene, applied physiology, and epidemiology. The principles and methods of epidemiology should be developed with particular reference to considerations of health.

The field of Occupational Preventive Engineering will include plant health inventories, a study of operations and processes, design and installation of equipment to control health hazards. It includes studies on ventilation, air purification, temperature-humidity control, illumination, noise, and housekeeping, and in addition, industrial pharmacology is of particular importance.

The physician who expects to attain success in the field of occupational health must have a working knowledge of the statistical method, and must possess a knowledge of the fundamental principles involved in insurance. The latter is true not only because of the contacts he has with workmen's compensation considerations, but because of the increasing importance of group insurance, sickness indemnification, and health insurance plans that are constantly under discussion. Finally, such a physician must be an administrative officer, not only in connection with the design, organization, and direction of the health service, but in connection with industrial organization, and the functional interrelations of the various departments of the

## THE SPIRIT OF THE GIFT

At the meeting of the House of Delegates held in New Haven on May 23, James Douglas Gold, chairman of the Trustees of the Building Fund, reported on the progress of the Fund to date. It was a gratifying report. $37,000 have now been pledged and of that amount almost one half in cash has been received toward the new home for the State Society. There is no doubt in the minds of the Trustees that the remaining $13,000 will be forthcoming and that at the December meeting of the House of Delegates the attainment of the goal of $50,000 will be announced.

Dr. Gold made no mention of the number of contributors. The quota of the Fund drive in dollars and cents is $50,000 but the quota in number of contributors is 100 per cent. By eliminating those of our members who are with the armed forces, it will be readily seen that a contribution of a little over $30 from each member would bring us to the desired goal. Many have given much more than this amount, but it is likewise true that many of our members as yet have contributed nothing. This may be intentional, but it is much more likely that the appeal from the Trustees has been laid aside for some more convenient time. Some have inquired how much they should give; others question the need of a building for the Society or prefer to wait until the plans are more crystalized.

In previous issues of the JOURNAL will be found statements by the president of the Society and the chairman of the Trustees as well as repeated editorial explanations and appeals. The facts have all been published. The need is recognized by the officers, council, and House of Delegates of the Society. To complete the Fund there remains only the response to be made by a number of our members whose home it will be. This should be accomplished before those who are with the armed forces return home. The amount needed from each member is not large. Three years have been arranged as the period of payment. This should not be a burden to any one.

"*The manner of giving is worth more than the gift.*"

organization, since the physician may be called upon as consultant by any or all departments. The relation of the plant physician to the family physician is particularly important. The physician-employee relation is successful to the extent that the plant physician develop a reference system with the family physician of the employee. Clinical occupational medicine is a field that should be developed largely by practitioners of medicine or surgery.

An attempt is being made in Detroit to develop an educational program for systematic instruction in the subjects required for developing physicians and engineers to apply their combined efforts in developing employee health programs in industry. The pattern for this program follows the needs as indicated above: namely, occupational preventive medicine, occupational preventive engineering, occupational health economics, occupational health administration, clinical occupational medicine, physical medicine, with particular emphasis on rehabilitation. An important feature of the school will be the development of facilities and opportunities for original investigative work in the field of occupational health and medicine.

## Professor Winslow and the Public Health Movement

The Yale Medical Library has now on display a special exhibit arranged in recognition of the distinguished services of Dr. Charles-Edward Amory Winslow, senior member of the faculty of the Yale School of Medicine who plans to retire at the end of June 1945. Since Dr. Winslow has for many years conducted seminars on the history of personal hygiene and the public health movement, the first part of the exhibit is devoted to early writings on hygiene beginning with Galen and his concept of

the "Non-Naturals" in relation of health. Galen maintained that environmental conditions affecting the health of the human body could be divided into three categories: things "natural," things "not natural," and things "against nature." Conditions not natural, generally referred to as the "non naturals," were six in number: (1) air; (2) meat and drink; (3) sleep and waking; (4) moving and rest; (5) emptiness and repletion; and (6) the affections of the mind—at least this was the phraseology employed in his *Castel of Helth* (1541) by Sir Thomas Elyot who was among the first to present in English the Galenical doctrines concerning health and sanitation.

A special feature of the exhibit is a copy of the rare first edition of Sir John Harington's *Metamorphosis of Ajax* which described his invention of one of the greatest of all sanitary conveniences, the water closet. The works of John Howard on Lazarettos and of Johann Peter Frank on Medical Police are also represented.

Five display cases are devoted to Professor Winslow's own writings. Since he has long been a stout protagonist of the view that adequate housing makes for adequate health of the nation, Professor Winslow's many sanitary surveys and reports on low cost housing are shown, also a selection of his many monographs and papers on ventilation and air conditioning. Dr. Winslow has been editor of two journals: namely, the *Journal of Bacteriology* and the *American Journal of Public Health*, the first since its inception in 1916 and the other since April 1944; in each instance the first volume to be issued under Dr. Winslow's editorship is displayed.

Dr. Winslow's voluminous contributions to the historical and biographical phases of the public health movement occupy a separate display case. His latest monograph entitled *The conquest of epidemic disease* was issued by the Princeton University Press and has had three printings since it was first issued in 1943.

The importance attaching to the historical backgrounds of the public health movement can best be expressed in Dr. Winslow's own words from his *Evolution and significance of the modern public health campaign* (New Haven, 1923): "There were two major tendencies dominant in the life of Europe a hundred years ago which were jointly responsible for the birth of the public health movement,—the development of the scientific spirit and the growth of a new motive of humanitarianism—both tendencies quite new in the history of the human race. The spirit of science made it possible for the first time to grasp clearly and confidently the possibility of a practical amelioration of the conditions of existence; and the humanitarian idea compelled vigorous efforts to accomplish such an amelioration in the interest of that portion of the human race which had hitherto labored under an accepted curse of misery and suffering."

## Medical Education — Old Purposes and New Methods

We are privileged to present in this issue the address of Dr. Henry R. Viets, given at the Medical Convocation, Brown University, August 9, 1944. The occasion was the establishing at Brown of a Department of Medical Sciences. The new department will assist the University in the general education of its students in matters of health, and through it the University plans to cooperate in the development of programs of postgraduate study and research for members of the resident staffs of the hospitals of the community. The history of the Brown University Medical School is an interesting one and Dr. Viets has brought to attention many important facts about its origin and its career. We are glad to learn more about these goings on, past and present, of our worthy neighobrs.

## The Diagnostic Clinic

The development of hospital and medical care insurance plans has shown that the public is becoming more and more aware of the importance and efficiency of group endeavor as applied to the care of the sick. Medicine itself shares this consciousness, for the advancement of medicine from the exercise of simple clinical observation to its present complexity has resulted in a specialization which, if not controlled by cooperative effort, will progress to the realm of absurdity. The awareness of this danger is shown by the tendency of medical practice toward group endeavor and the development of hospitals along lines which will favor such enterprise. Much remains to be done, however, for the lack of definite organization of such groups still means a great deal of waste effort on the part of physicians and a similar wastage of time on the part of the patient who may be seeking the benefits to be gained from the opinion of those working in special diagnostic fields.

The diagnostic clinic, well organized and closely related to hospital and laboratory facilities, is a clear

nswer to this problem and it seems certain that the evelopment of such groups within our state would e welcomed by the profession and public alike. It ; also true that if and when the public demand for ypes of so called prophylactic medicine becomes nanifest, such as the complete periodic physical xamination, the cancer detection clinic, etc., such roups would be in a strategic position to aid in atisfying that demand.

The thought has occasionally been expressed that development of medicine along these lines might nterfere with individual private practice and in the nd displace much of that practice. This is not likely or, in spite of the evolution of medical science to :s present high level, the basis of medical practice as continued to preserve the physician-patient elationship on its present individual basis. Furthermore, the diagnostic clinic should become a very mportant aid to the private practitioner, offering to im and to his patient an efficient type of service at resent not possible.

In Connecticut there are certain places where rom a point of view of population density such liagnostic services could well develop. Fortunately, hese urban centers are quite adequately supplied vith good hospital and laboratory facilities, so that rganization in such centers would not be too difficult. In the beginnings such organization in most nstances would be somewhat loosely knit, developng into closer relationships as function progresses.

In the development of this type of medical practice it must be clear that for its best organization nd function its management should be completely n the hands of the participating physicians. There re several well known clinics in this country now managed by medical groups and in which the fees for service are used to pay salaries and other operating expenses. In certain clinics associated with medical schools such fees are used as clinical funds o aid teaching and research programs. In the diagnostic clinic, which may be developed around the small voluntary hospital, it is obvious that fees for medical service should go directly to those physicians giving that service. It is likely, however, that a certain amount of this money could be usefully turned back into the clinic to further its efficient operation.

Whatever one may think on this subject, it is certain that now is the time for leaders in our hospital staff groups and in our hospital directorship groups to be thinking on developments in this direction.

## The Need at Gaylord Farm

Explaining the contemplated program of enlargement and improvement for which $600,000 is needed, Gaylord Farm Sanatorium has distributed a brochure entitled "Guarding Human Resources." The cover illustration contributed by Stevan Dohanos pictures part of the sanatorium's beautiful gateway, a unique gift symbolizing the gratitude of "graduate patients" and dedicated by them in 1921 to Dr. David Russell Lyman, superintendent of Gaylord since it was founded in 1904. According to custom a patient may ring the bell twice: once when he first goes "on exercise" and again when his treatment at the sanatorium has been completed.

No one who is familiar with Dr. Lyman's accomplishments at Gaylord over a period of forty-one years will question for a moment the need for larger quarters. Over 7,000 patients have passed through its doors. The present infirmary and the cottages for housing the ambulatory patients are no longer adequate. The x-ray department, a vital necessity, also must be enlarged. The endowment fund, which has been one of the sources for making up the deficit between the $15 weekly charge and the $30 weekly cost for each patient, must be increased if the financially handicapped patient is to be cared for at Gaylord in the future as in the past.

Many opportunities for memorial gifts are now available. David Lyman has a host of friends who will come to his aid in this time of need. Not many of his medical confreres will be in a position to add very materially to the amount needed for more efficient care of the tuberculous, but all who know him and of his years of service can assist in acquainting the public with the need at Gaylord Farm.

## Unhappy Experiment

The Rhode Island Sickness Fund, which is the most extensive experiment in state health insurance, faces insolvency. The Fund does not provide medical care but provides a weekly cash indemnity for covered persons when they are sick.

If the present pattern of rising disbursements and declining contributions continues and no action is taken to tighten up on eligibility for benefits, the Fund will be insolvent in 1947. The system appears headed for a $1,000,000 deficit this year, nearly twice the 1944 deficit of $587,327, as its resreve fund dwindled from a peak of $3,815,686 at the end of February 1944, to $2,720,206 last April 30. Benefit payments during the first week in May were the

highest in eight months, and the receipts last month were 27 per cent below the Fund's income in April 1944.

At the time the law creating the Fund was passed it was anticipated that tax income would not be sufficient to meet the demands made and experience shows invariably that demands under these systems always exceed what is planned.

## Cancer Records in Connecticut

Under this title *The Lancet* of May 5, 1945 makes the following editorial comment:

CANCER RECORDS IN CONNECTICUT

The methods adopted by the Department of Health in the State of Connecticut to facilitate cancer research and encourage early treatment deserve study in this country, particularly now when our new system of recording cases of cancer is under trial. Eleanor J. Macdonald, the research statistician, discusses the survival rates of people with proved cancer and explains how the figures are obtained. A special effort was made to get a follow-up of all cases of cancer treated in Connecticut since 1935, with the result that many cases of proved cancer were found to be alive and well. It is believed that the records of these patients can be used to teach the general public that cancer is an ordinary disease, dangerous but curable, about which they should know enough to seek medical advice if they need it.

Miss Macdonald's paper, one of several similar publications, may be regarded as cancer propaganda of a simple and satisfactory type. She ponts out that the crude death rate from cancer is fairly constant, showing how much remains to be done, but the divergence between the primary hospital admission rate for cancer and the cancer death rate is getting steadily wider. In the past the number of deaths from cancer and the number of patients admitted to hospital suffering from cancer were approximately the same in any one year, so, although patients dying were in most cases not those first recorded that year, it seemed that practically all cases of proved cancer died of that disease. Now for a number of years considerably more patients have been admitted for cancer but the death rate has not risen, an indication that an increasing number of the cases treated are either cured or have their life much prolonged. Early treatment remains the obvious method of increasing the survival rate, and only by the collaboration of everyone concerned, whether in diagnosis, treatment, or education, can awareness of the symptoms of cancer be inculcated without frightening the individual.

The Connecticut system might well be adapted to meet the needs of the Regional Cancer Organization now taking shape in Britain. Beginning at the periphery, small meetings and discussion groups often taught by the local doctor, obtain the interest of lecturer and listener, and this leads to earlier diagnosis. Special clinics in local hospitals, where points are allotted on which claims for payment for the investigation of patients suspected of cancer may be made, form the next link in the chain. Treatment in central hospitals which provide the most modern specialized methods gives to all proved cases the best possible chance of cure; and finally a careful system of follow-up and aftercare provides data for research and ensures that no patient relapses merely from lack of skilled attention.

## William W. Herrick

The death of Dr. William Worthington Herrick on May 31 in New York City will be noted with deep regret by many members of our Society. Dr. Herrick had deep roots in Connecticut soil for he was born in Sherman in 1879, educated at Hopkins Grammar School and at Yale University where he graduated in 1902 and the Yale Medical School where he received his medical degree in 1905. Widely known as an internist and consultant he was professor of clinical medicine at the College of Physicians and Surgeons at Columbia University. At the time of his death he was President of the New York Academy of Medicine. Throughout his life Dr. Herrick maintained a sincere interest in medical affairs in Connecticut and on numerous occasions was a guest speaker at our county and state medical meetings. He had a country home at Sharon and his burial was in that town.

## A. M. A. House of Delegates Meeting Denied

An application for a permit to hold an annual meeting of the House of Delegates of the American Medical Association in Chicago July 23 to 25 has been denied by the War Committe on Conventions. Since permission could not be secured during the month of June, application was made for the last week in July with the view that those dates would antedate the movement of large numbers of troops from the European areas to the United States.

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## COUNCIL MEETS TWICE

### James R. Miller Reelected Chairman

The Council had a special meeting immediately following the annual House of Delegates meeting on May 23. There were present: Drs. Miller, Mullins, Murdock, Thoms, Weld, Weed, Gildersleeve, Gibson, Campbell, Howard and Barker. Absent: Drs. LaMoure, Paine, Speight and Moore. The regular monthly meeting of the Council was held on June 1 and there were present: Drs. Howard, Gibson, Mullins, Weed, Speight, Thoms, Gildersleeve, Paine, Miller, Weld and Barker. Absent were: Drs. Moore, LaMoure, Murdock and Campbell.

Dr. Miller discussed the progress that had been made with the organization and incorporation of Connecticut Medical Service and stated that the first meeting of the incorporators and Mr. Arnon Thomas, counsel for the Society, would be held on May 25. The Council voted that all of the original incorporators should be selected by the State Medical Society and that the By-Laws of the new corporation should include provision that all incorporators should be nominated by the Society.

Dr. Howard extended his report that he had made before the House of Delegates earlier in the afternoon concerning the Detroit conference of State Medical Society presidents and the projected medical-radio program. Dr. Howard asked that a consulting panel on the subject of public relations be provided for him and the Council directed that the Society's Committee on Public Relations be designated for this purpose. Advice from this committee will be sought relative to the Society's participation in the radio program that has been proposed.

There was discussion of the possibility and desirability of holding the Clinical Congress in September of this year as usual and it was voted that the Clinical Congress Committee be directed to make preliminary arrangements and set dates for the Congress and then permission to hold it would be sought from the Office of Defense Transportation.

The annual meeting of the Council was held at the offices of the Society on June 1. Dr. Miller was reelected chairman for the year 1945-1946. The Executive Committee of Drs. Miller, Howard, Gibson, Murdock and the secretary was appointed to act for the Council during the summer months when no regular meetings would be held.

It was voted that the Council should act as an advisory committee to the State Commissioner of Education on the approval of schools and hospitals for the training and education of veterans, under Public Law 346, and it was further directed that the Council should seek advice from committees of the Society in special cases.

It was voted to approve the request of the Committee on Tumor Study seeking permission to revise the By-Laws of the Connecticut Cancer Society so that in the future it will not be required that a majority of the Board of Trustees of the Cancer Society be members of the Tumor Committee of the Connecticut State Medical Society.

An invitation having been received from the Rhode Island Medical Society to participate in the reactivation of the New England Council of Medical Societies it was voted that this Society send three delegates to the proposed organizational meeting of the Council which is to be held in Providence at an early date. The delegates named were Drs. Miller, Howard and the secretary.

A letter was read from the secretary of the Trustees of the Connecticut Hospital Association that another conference on the subject of the practice of radiology in hospitals would be arranged for the Council with the Board of Trustees of the Hospital Association some time during June.

It was voted that three members of the Council be appointed a committee to cooperate with three members of the Section on Radiology, to be ap-

pointed by that Section, to take a referendum on the subject of radiological practice in hospitals that was voted by the House of Delegates on May 23. The committee from the Council consists of Drs. Murdock, Howard and Gildersleeve.

The newly appointed Executive Committe of the Council was directed to formulate plans for the organization of a "Connecticut Council on Medical Care," by vote of the House of Delegates on May 23, and that the Executive Committee be directed to report its plans to the Council at its first regular meeting following the summer recess.

The matter of the rebate of 5 per cent commissions to the secretaries of the County Associations for the collection of dues was discussed at length and it was voted that:

(a) The practice of paying a 5 per cent commission to County Association Secretaries (or treasurers) for the collection of dues be continued throughout the year 1945. Commencing with the year 1946 the payment of the 5 per cent commission will be discontinued. (b) The treasurer of the Society was directed to prepare and distribute to the county secretaries (or treasurers) regulations covering the collection of dues as provided in Article XIII, Section 10, paragraphs 1 and 2 of the new By-Laws of the Society, and these regulations set forth to the County Associations their option of collecting State and County dues as at present or having the State and County dues collected by the office of the State Society and in the event a County Association elects to continue to collect State and County dues the State Society will reimburse the County Association at thirty-five cents per capita for all dues collected.

Dr. Howard reported further on the subject of the radio program and on the conference which he attended in Buffalo on May 25 and on the meeting with the Society's Committee on Public Relations in Hartford on Sunday, May 27.

Thirty-one additional student members were elected to the Society which makes a total student membership of approximately 200.

The Council appointed a special committee to study the operation of the Workmen's Compensation Law particularly as it relates to the free choice of physician by injured workmen. The committee appointed is: Lawrence S. Ward, Niantic, Chairman; Andrew J. Jackson, Waterbury; James D. McGaughey, Wallingford; Daniel C. Patterson, Bridgeport; and Karl T. Phillips of Putnam.

The meeting adjourned at 6:40 P. M.

## Yale Receives Further Grant for Optical Study

On May 27 Yale University announced an additional grant by the American Optical Co. in further support of the research program of the Clinic of Child Development of the School of Medicine.

The grant to the program, which includes investigations of the development of visual functions in the first ten years of life, covers the three year period from 1945 through 1948.

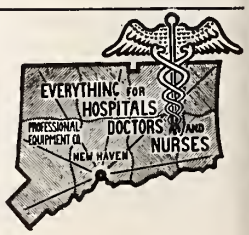
The research work is being conducted on a cooperative basis by a medical and psychological staff, under the direction of Dr. Arnold Gesell, professor of child hygiene and director of the clinic of child development. Chief emphasis is being placed on problems of early diagnosis and of preventive control.

## Medical Care in Westchester County

Boyden Roseberry, managing editor of the *Westchester Medical Bulletin*, has published the findings obtained from a study of the distribution of medical care in Westchester County, New York. A few of his figures are of interest. In 1940 Westchester County had 611 general practitioners or 1 to 941 of the population; in 1945 there are 352 general practitioners or 1 to 1,477 people. The county has 3,291 beds in general hospitals, a ratio of 6.3 beds per thousand of population. The same ration for the United States is approximately 1.5 general hospital beds per thousand people. Westchester County apparently is well provided for in both physicians and hospital beds in spite of a loss of 334 physicians into the armed forces.




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(SEE PAGE 2)

## STUDENT MEMBERS ELECTED BY THE COUNCIL JUNE 1, 1945

### Fairfield County

| NAME | FATHER'S NAME | MEDICAL COLLEGE | HOME |
|---|---|---|---|
| Finkelstone, Edward R. | G. N. Finkelstone | P. & S. Col. | Bridgeport |
| Garamella, Joseph J. | J. V. Garamella | Georgetown | Bridgeport |
| Lee, John F. | R. A. Lee | Cornell | Greenwich |
| Parmelee, Kenneth A. | B. M. Parmelee | U. Vermont | Stratford |
| Stubenhaus, Jay H. | E. H. Stubenhaus | N. Y. Med. | Fairfield |
| Tulchin, Janice H. | Lewis Tulchin | N. Y. Med. | Norwalk |
| Walser, Mackenzie | K. E. Walser | P. &. S. Col. | Darien |
| Walsh, James F. | J. F. Walsh | N. Y. Univ. | Bridgeport |
| Watt, Robert D. | R. B. Watt | Tufts | Bridgeport |
| Weise, Ellwood C., Jr. | E. C. Weise | Jefferson | Nichols |
| Stewart, William W. | Intern at Stamford Hosp. | Hahnemann | Stamford |

### Hartford County

| | | | |
|---|---|---|---|
| Anderson, Gustave W. | Father deceased | Jefferson | Hartford |
| Bissell, William B. | Karl H. Bissell | N. Y. Med. | Suffield |
| Cooper, Robert R., Jr. | R. R. Cooper | Yale | E. Hartford |
| Hayes, Robert D. | Matthew J. Hayes | Boston U. | New Britain |
| Maxfield, Wesley B., Jr. | W. B. Maxfield | Syracuse | Hartford |
| Scheer, Edward H. | C. T. Scheer | Tufts | Kensington |
| Tamoney, Harry J., Jr. | H. J. Tamoney | Long Island | W. Hartford |
| Turner, Wilbur S. | H. A. Turner | U. Buffalo | Hartford |
| Vernlund, Robert J. | C. F. Vernlund | U. Vermont | W. Hartford |

### Litchfield County

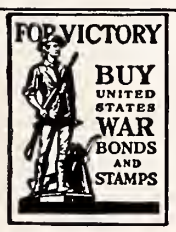
| | | | |
|---|---|---|---|
| Titherington, John B. | Father deceased | Harvard | Litchfield |

### New Haven County

| | | | |
|---|---|---|---|
| Alderman, Donald B. | S. W. Alderman | Long Island | New Haven |
| Arnold, William P., Jr. | W. P. Arnold | P. & S. Col. | Middlebury |
| Audet, Robert J. | C. H. Audet | U. Maryland | Waterbury |
| Boynton, Robert D. | H. D. Boynton | Boston U. | Hamden |
| Cugell, David W. | Father deceased | Long Island | New Haven |
| Hall, Mary N. | Joseph Hall | Albany | New Haven |
| Minor, James V., Jr. | J. V. Minor | Georgetown | New Haven |
| Shindell, Sidney | B. A. Shindell | Long Island | New Haven |
| Sumner, Martin L. | Father deceased | N. Y. Med. | New Haven |

### New London County

| | | | |
|---|---|---|---|
| Murray, Joseph T. | T. J. Murray | N. Y. Univ. | New London |




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(SEE PAGE 2)

# ADDRESS OF THE PRESIDENT, JOSEPH H. HOWARD, TO THE HOUSE OF DELEGATES

MEMBERS of the House of Delegates: I assure you that I am highly honored in being chosen as president of this Society. The task of the president of this Society is not an arduous one. With men such as Creighton Barker, Jim Miller, our efficient Councillors and the various committees things run along very smoothly.

There are some things I think perhaps we should think about in the next year or two, and a few of these were mentioned in a rather indirect way. I should like to see this year particular emphasis placed on public relations. Dr. Burlingame in his report has suggested, and it has been carried through already, I believe, in the appointment of committees, a new set-up in the Public Relations Committee. We find, as we go throughout the country, considerable criticism from the public regarding our relationship to the public. They feel that we have lost contact with the public. Perhaps we have been so rather self-centered and so busy with our work that we haven't mixed with the public as we should. The result has been that a minority, and a rather powerful minority, has been able to bring before various state legislatures, and before the Congress, various bills which are detrimental to the practice of medicine. We have been confused. We haven't had a leader.

We look to the American Medical Association for leadership in these times, and unfortunately, we haven't found it. As a result, there has been a falling down in this leadership, which has been taken up with different groups throughout the country, trying in their own particular way to lead on. The result has been that in California, in Michigan, in Indiana, throughout the country, these various groups of physicians have tried to develop some system for combatting this legislation.

It is because of these different groups working in different ways that we have not gotten anywhere. We must unify this whole thing if we are going to combat this type of legislation. The first thing that the various societies attempted to do, therefore, was to set up a prepaid medical plan. And various states have some type of prepaid medical service at the present time. But we know from the word of Senator Pepper that that is not enough. Senator Pepper and his committee say that the prepaid medical plans, as set up now, are not acceptable. The only plan that willl be acceptable to their committee is an all out plan which will cover all forms of illness and disease, and cover all the people. And so therefore, these plans will not be accepted.

About a month ago the president of the Michigan State Medical Society invited seventeen presidents of state medical societies in the northeastern part of this country to meet in Detroit to discuss this subject of public relations. Dr. Jarvis couldn't attend, and I went in his place. To show the interest in this thing, the seventeen presidents of these various societies appeared, everyone of them. And for two days we discussed various phases of this public relations problem. Out of that meeting there came two resolutions. One was to establish in the various states a panel of physicians who would work on some plan or system for presentation to a meeting to be held very shortly, at which time these various plans will be crystallized, and then brought to the American Medical Association for presentation to Congress, if necessary.

There were several important points brought out at that meeting. In the first place, one of the most prominent members of Congress was touring the Willow Run plant with Dr. McClure, the chief surgeon of the Ford Motor Company, and told Dr. McClure that he was not in favor of the Wagner-Murray-Dingle Bill, but some form of legislation would be put through, and since American medicine had not presented any plan, that this or some modification would be passed.

That, I think, was a challenge which we should accept. Two very prominent members of the legislature, almost as prominent as the first man, have volunteered to present to Congress any plan which American medicine can present to them. And yet we have not presented a plan.

There is one other thing besides this panel which is to be organized in the various states, and that is the suggestion of a radio program. When I first heard this I was a little skeptical about it, skeptical because I knew that conservative New England would not take to it very easily. But after studying the thing and talking to these various men, I rather was in favor of it, and I am going to talk to the Council after this meeting, hoping that they may accept it and enter into this plan.

I am going to Buffalo tonight to discuss this further tomorrow with a committee, and I hope that I will have the support of your Council. The presidents of these seventeen state societies that met in Detroit represented states comprising about seventy-one million people. They also comprise 75,000 physicians. So you see, these seventeen states make up a good portion of the population, both the lay population and the medical population of America.

It is the plan, therefore, to have a broadcast at the same hour over a group of very powerful stations once a week for fifteen minutes. Now I think most of you agree that the ordinary medical broadcast is rather flat. People do not listen to a doctor talking on the radio. They are very apt to come home tired in the evening, and when they hear someone speaking, unless it particularly appeals to them, they will shut it off and turn on music. And so this program is a very dignified program in which there is some very fine music and a short talk by a prominent physician, followed by more music. And the whole thing as demonstrated and broadcast in Detroit to us seemed to me very acceptable.

You know that osteopaths, chiropractors, natureopaths, and such people spend a lot of money on propaganda. We in the medical profession have never been taxed to pay for any form of education of the public. This is going to cost money. A thirteen weeks' program, once a week, will cost the members of the profession in these seventeen states eighty-four cents per member. This same broadcast, which has been carried on in the State of Michigan during the past year, has cost the Michigan State Medical Society $21,000. They pay it out of their treasury. The reason that they can spend $21,000 is that the members of the Michigan State Medical Society are assessed ten dollars a year for public relations. And I think if we are going to carry on any form of public relations program in the State of Connecticut, it may be necessary to assess our members. There are several other phases of this public relations group which I would like to talk to you about, but I know it is getting late, and I have to go down and see the Woman's Auxiliary in a few minutes. But I want to leave this message with you, that I do think we must become a little more aggressive, that we must get into closer touch with the public. We must become more civic minded in matters of health than we have previously.

There has been a reluctance, I know, in my community on the part of physicians to enter into civic organizations in which health matters are concerned. We leave it to the lay people to settle.

And so I leave you with that in mind, the thought that during this present year, this next year, we shall concentrate with our Public Relations Committee, and possibly dovetailing in with the suggestion that Creighton Barker has made of this new health committee throughout the state, that we may be able to carry through a little closer cooperation between the profession and the public than we have had in the past few years.

## CONNECTICUT IN FIRST PLACE IN CANCER CAMPAIGN

EDWIN R. MEISS, *Managing Director Connecticut Cancer Society, Inc.*

THE Connecticut Cancer Society raised over $143,000 in its recent campaign, passing its national quota and leading all other state organizations in the total amount of money reported. In addition, the third smallest state had the first two cities of over 100,000 population to go over the top. They were New Haven and Hartford, who exceeded their quotas by a large margin before the end of the campaign.

Besides raising funds, the Society fulfilled the educational purpose of "Cancer Control Month," as designated by Act of Congress, by distributing during April an unprecedented amount of educational material and reaching the people of the state by radio, screen, and news publicity with its appeal for cancer control through early diagnosis.

As a result of the success of the drive, approximately $80,000 will be available for education, care of patients and cancer control projects in Connecticut during hte coming year. Of the $63,000 which will go to the American Cancer Society for purposes of national organization and research, a share may return to the state in the form of grants for research projects.

To plan the expanded Connecticut program and administer the funds several new committees will function for the Society. A Medical Advisory Committee will consider or initiate scientific pro-

posals. A Finance Committee of business men will pass on expenditures. Educational activities will be guided by a Public Education Committee, with members drawn from the fields of educaiton, medicine, and publicity.

The cancer campaign opened in April and was extended to May 15. In previous years the Field Army of the Cancer Society through its volunteer workers had conducted an annual campaign of education and membership enrollment, but the 1945 quotas were set at ten times the amount raised in the past. Business men throughout the state agreed to act as campaign chairmen and to seek the support of business and industry. They cooperated with the Field Army in raising Connecticut's share of a $5,000,000 national fund to launch a comprehensive attack on cancer. Physicians in many localities worked actively with campaign groups or helped by addressing meetings.

The interest and response of the public were unusually gratifying, according to volunteer workers who had solicited for other causes. People were eager to give, they said. Many had lost a friend or loved one through cancer. They had a variety of misconceptions and fears. They wanted to ask questions and were relieved to know that cancer was not improper to discuss.

A surprising number of persons volunteered the information that they were "cancer cures," and wanted to help because they realized the importance of recognizing early symptoms. Checks for relatively large sums came from plain people, often with earnest letters of hope that science might be empowered to find the answer.

Various methods of solicitation were successfully used. Individuals in the larger cities were reached by mail, with some telephone follow-up contacts. In many small towns enterprising workers visited every house and obtained almost a 100 per cent response. Mail appeals and personal contacts were used to reach business and industry, and coin boxes to give the employees an opportunity to contribute. After a sensational one-day campaign at the Pratt & Whitney Company in Hartford, an armored car had to be sent to transport coin boxes containing a total of $4,040.30.

As a result of the campaign the Connecticut Cancer Society has thousands of new members. It owes a debt of gratitude to the many business men, Field Army volunteers and other workers who put Connecticut out in front of all states, large or small. By enlarging the Board of Trustees to include some of their number, the Society plans to retain their active interest in its work.

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## A. M. A. Journal Says Rankin Bill Gives No Consideration to Men Involved

Representative Rankin's proposed bill to establish a Department or Bureau of Medicine and Surgery in the Veterans Administration is condemned by *The Journal of the American Medical Association* because "nowhere is any consideration given to the rights of the men involved."

In its issue of June 2, *The Journal* says:

"This legislation, in addition to establishing a Bureau or Department of Medicine and Surgery in the Veterans Administration, proposes that commissioned officers and non commissioned personnel of the department or bureau may be detailed for service with the medical services of the Army and Navy and that commissioned, appointed or enlisted medical personnel of the Army and Navy may be detailed for service with the Veterans Administration when such detail, in the judgment of the heads of the agencies concerned, or of the President, will promote the public interests without impairing the efficiency of the service or services involved. Nowhere is any consideration given to the rights of the men involved. It is further provided that members of the newly to be created Department or Bureau of Medicine and Surgery will be exempt from selection or draft for service with any other component of the armed forces but that any personnel needs of the bureau or department may be filled by assignment of selected or drafted persons. Under this broad authority it would be possible for physicians to be drafted for assignment to the Veterans Administration. Here is more compulsion! Instead of attempting to attract more and better physicians to the Veterans Administration by improving the quality of the service and by making positions sufficiently attractive to well qualified men, these measures propose—at least during wartime—to force physicians who enlisted voluntarily with the armed forces into assignments with the Veterans Administration. The damage that has been wrought to medicine by the destruction of premedical classes, by the threat of state medicine and by the compulsion which has already forced hundreds of physicians into the Veterans Administration is incalculable. The nation will reap this sad harvest for generations to come."

## Dr. F. G. Blake Receives Award at Providence

The Charles V. Chapin Memorial Award, presented annually by the City of Providence, Rhode Island, was awarded on May 16 to Dean Francis G. Blake, dean of the School of Medicine and Sterling professor of medicine.

The presentation was made at the 134th annual meeting of the Rhode Island Medical Society, at a two-day scientific symposium in Providence. Mayor Dennis J. Roberts of Providence made the presentation on behalf of the Society in recognition of Dr. Blake's work in the field of infectious diseases.



Presentation of the Dr. Charles V. Chapin Award of the City of Providence for 1945

*L to R*—Dr. Roger I. Lee, President-elect of the American Medical Association; Hon. Dennis J. Roberts, Mayor of Providence; Dr. Francis G. Blake, Dean and Sterling Professor of Medicine, Yale University Medical School, the recipient of the award

Dr. Blake, delivering the fourth annual Charles V. Chapin Oration, presented a paper on "Some Recent Advances in the Control of Infectious Diseases."

## Dr. Naylor Honored

James H. Naylor of Hartford recently received an honorary degree of Doctor of Laws from the University of Vermont. A member of the University's Medical School, class of 1895, Dr. Naylor was an honor student and a star athlete throughout his college years. He played third base on the Vermont baseball team which went to the World's Fair in Chicago in 1893. The conferring of the degree recently, was on the occasion of his fiftieth reunion.

President John Schoff of Vermont in presenting the degree to Dr. Naylor, made the following citation:

"James Henry Naylor, because you have been a successful practitioner of medicine and a public spirited citizen, giving unstintedly of your time, energy and means in behalf of education and public health; because your long career exemplifies the qualities which the University of Vermont hopes to find in its graduates, we are happy to honor you. By virtue of the authority vested in me, I confer upon you the degree of Doctor of Laws, honoris causa, and admit you to all its right and privileges."

A native of Schuylerville, N. Y., Dr. Naylor practiced pharmacy for a year and a half, subsequently received his medical degree cum laude and interned at the Hartford Hospital from 1895-1897. Later in 1897 he started his public practice.

Now a member of the Hartford Board of Education, Dr. Naylor was for 10 years a member of the high school committee and for more than 25 years a member of the South School District committee. In the latter position, he started the first health crusade for children, with the introduction of school dentists, nurses, physical instructors and immunization.

Dr. Naylor was a member of the building committees for the Broad Street addition to the Hartford Public High School, the Weaver High School, Bulkeley High, the Burr Junior High and the Kinsella and Naylor schools.

He has served as commissioner of the Norwich State Hospital and as a member of the Hartford Board of Finance. He was a physician with the draft board of World War I and is now serving as chairman of Draft Board 3 of Hartford.

## Colonel Tovell Elected

Colonel Ralph M. Tovell of Hartford, chief of the anesthesia department of the Hartford Hospital, was elected vice-president of the American Board of Anesthesiology at its annual meeting held in New York City in June.

Colonel Tovell has been in the service for 34 months, 33 of which have been spent overseas as chief consultant on anesthesia for the European Theater.

Philip D. Woodbridge, of Reading, Pa., formerly of Hartford, was elected president and Paul M. Wood of New York City, secretary and treasurer. Colonel Tovell was also re-elected to the American Medical Association section on anesthesiology for a six-year term.

## Blue Cross of Rhode Island Increases Benefits

Since its beginning nearly six years ago, the Blue Cross of Rhode Island, a non profit organization, has maintained a policy of periodically increasing benefits to its subscribers. Recently Blue Cross announced to its 275,000 members a new plan of hospitalization which effective June 1, 1945 will replace all present ward and semi-private plan contracts.

The new plan for groups is called the STANDARD GROUP PLAN and it provides for new benefits, which have been liberalized in ten ways. Also, the present six monthly rates are replaced by only two monthly rates. Among the increased benefits are the following:

(1) Up to *62 days of hospital care* each contract year of from 21 to 30 days. Not more than 31 days for the same cause.

(2) Room and board up to $6 *per day* instead of being limited to ward or semi-private accommodations.

(3) *Extra days* of hospitalization, if needed, when accommodations used cost less than $6 per day.

(4) In addition the following extra services will continue to be covered in member hospitals, regardless of cost: operating room, as often as necessary—all ordinary medicines, *including penicillin*, and surgical dressings—all laboratory examinations—basal metabolism tests—oxygen and serums—physical therapy.

(5) *Maternity cases* requiring additional surgical procedures, such as Caesarian section, removal of tumor or cyst, will *now* be entitled to regular Blue Cross benefits.

(6) Maternity allowance *increased $65* instead of $36 under the Ward Plan and $54 under semi-private.

(7) *Waiting period* for maternity benefits reduced from 9 months to 7 months.

(8) *Newborn children* automatically covered from date of birth.

(9) Non member hospital allowance increased up to $6 per day for room accommodations, *plus $30* for extra services as listed in (4) above.

(10) Operating room and emergency accident room service up to $7.50 for members who are not bed patients.

Although the cost of these greatly increased benefits will be substantial, Blue Cross feels that with a reserve fund for contingencies of over a million dollars benefits can be safely provided at the rates outlined. With nearly 40 per cent of the State's population enrolled, Blue Cross now ranks 19th in size of the 80 Blue Cross Plans approved by the American Hospital Association.

## School Health Conferences To Be Continued

Preliminary plans for the continuation of the school health conferences sponsored for several years by the Connecticut Tuberculosis Association, the State Departments of Health and Education and local health and education departments were discussed at a meeting of representatives of the various groups held at the New Haven Medical Association on May 22. Dr. Herbert Walker, Hartford, presided at the meeting and introduced Colonel Ira V. Hiscock, New Haven, Miss Mabel Baird, Hartford, N. Searle Light of the State Education Department, Dr. Elizabeth C. Wells of the State Health Department and others who reviewed the development and organization of school health meetings. The relative advantages of state, regional and local conferences were analysed at some length and it was agreed that even in a small state all three types of meeting can be profitably arranged. The importance of careful investigation of the job to be done, i.e., local problems, needs and objectives, rather than imposition on the community of a ready made program was stressed. It was the consensus of opinion also that the success of the conferences is contingent upon the participation of all groups and agencies concerned in maintaining and improving the health of children, particularly parents, upon utilization of local resources and talent wherever possible and the increased use of health education media not only during the conferences but for publicity purposes preceding the meetings.

# MEDICINE AND THE WAR

## A Hartford Physician in the Fight Against Malaria

*Released by the Press Censor, India-Burma Theatre*

New Delhi, India—While American armies have been winning decisive victories in the Far East, little known medical units in India and Burma have been winning a prolonged, exacting struggle against one of mankind's most dread diseases—malaria.

One of the world's worst malarial areas stretches across India and Burma, where Americans in 1942 were assigned to work and fight after the Japanese conquest of Burma and the enemy's initial threat to the security of India itself.

Exact figures cannot be given because of military security, but rigid malaria control in the India-Burma theater has cut malarial incidence among American troops to a fraction of the casualties from the disease during the early appearance of American troops in upper Assam and northern Burma—areas where the native population was infected almost 100 per cent.

Stringent control measures have reduced the malarial rate to less than one-eighth of the original figures predicted by British officials.

When work began on the Stilwell Road, troops in the Ledo area were infected in large numbers, and those who hadn't yet experienced the alternating chills and fever of malaria were, according to one Army official, expecting to be stricken with the disease.

By early 1945, as troops once again awaited the approach of the drenching monsoon rains and the resultant climb in malaria incidence, malarialogists of the theater surgeon's office and the troops themselves were certain that their malarial rate would not climb on the charts which showed a sharp, steady drop over the months during which Americans have been stationed in this part of the world.

Troops in India and Burma were charged primarily with supplying China. To do this, a land route was needed to augment air supply after the old Burma Road was closed. The area over which the land route necessarily had to run—because of enemy occupation—extended through the worst malaria area in the world.

When troops first arrived in India, they were told flatly their job just couldn't be accomplished. And the main reasons were not Jap opposition or terrain or weather. All of these were contributory, but the greatest deterrent of all to the accomplishment of the American mission was malaria.

These predictions of failure were alarmist and defeatist, but they were based on vital statistics which showed that more than 100,000,000 persons are afflicted with malaria every year in India. More than 1,000,000 of these die from the disease every year.

At that time—early 1942—Indian and British troops fighting in the 100 per cent infected areas of Assam and Burma had suffered many times more casualties from malaria than from enemy action. Often malaria alone decided the issue, and quite often the decision was in favor of the Japanese.

Americans were inclined to heed the pessimistic statements. They did not belittle the predictions of their allies nor did they place unlimited faith in their ability to conquer the disease. They were sobered by the knowledge that at that time malaria had not been conquered in the Southwest Pacific. Malaria for a time held the balance of power in that area, and it consistently claimed four to six times the casualties in battle.

For 20 years an American doctor, Earl M. Rice, had operated his own hospital in Assam. He knew the country intimately, he had made a lifetime study of malaria, he had been closely associated with both British and Indians and he spoke the native language fluently.

Tropical medicine was Rice's specialty. He was a member of the American Society of Tropical Medicine and a fellow of the Royal Society of Tropical Medicine. He was born in 1891 in Hartford, Conn., earned his M.D. degree at the University of Oregon in 1915, and claimed South Carolina as his legal residence.

With a specialist's knowledge of malaria and with his long residence in the heart of the area where malaria had to be whipped, he was the ideal man to handle the job.

Rice was commissioned a lieutenant colonel in the Army medical corps and assigned the task of con-

trolling the scourge which, if left unchecked, would most surely neutralize the American effort in India and Burma.

Meantime, as a result of medical experience on Guadalcanal, two types of organizations were being formed and trained in the United States to combat malaria—control units and survey units.

Control units consisted of a sanitary corps officer with engineering background and 11 enlisted men. Their job was actual physical control—drainage to eliminate breeding spots, oil and Paris Green (an arsenic compound) spraying to kill larvae, mosquito-proofing quarters to prevent bites by the infected insect, and spraying to kill the adult mosquito.

Survey units laid the groundwork for control. They evaluated areas as to their relative importance as breeding centers, decided which to treat first, and examined blood and spleens of native children to determine incidence. Their personnel consisted of two officers, an entymologist and a parasitologist, and 11 enlisted men.

Equipped with complete portable laboratories, these highly trained specialists worked ahead of and with the control units. When they found enlarged spleens in children up to 12 years of age, they knew they were dealing with a population actively infected with malaria. (Children provide a more accurate criterion of the degree of active infection because of the immunity factors in adults which make a spleen reading unreliable.) Then they took blood smears to determine the parasites.

Malarialogists say that a 25 per cent spleen rate is bad, but in Assam and Burma the rate consistently exceeded 90 per cent and often rose to 100 per cent.

Shortly after Col. Rice took over his tremendous job, two of each of these units were obtained from the United States and put to work. During the ensuing period, the number of survey and control units increased greatly.

Normal delays were encountered during this early period because of the inability to get equipment and supplies rapidly from the states. Had not the War Department given malaria control supplies a shipment priority equal to that of food and ammunition, the fight would have been prolonged at the expense of soldiers' health and lives.

Sections of India and Burma each presented problems peculiar to the area. The *anopheles philippinensis* was worst in Bengal. This species multiplied rapidly in innumerable ponds and tanks which were virtually impossible to drain.

Assam, dotted with tea plantations and rice paddies, was found to be a hyperendemic area—with 50 per cent or more of the population stricken. Seepage areas were worst during the monsoons. And the *anopheles minimus*, probably the most violent mosquito carrier known, was the prevalent type of species.

In the Patkai hills—foothills of the Himalaya mountains—along the Assam-Burma border, where the Stilwell Road now threads its way toward China, thick vegetation along mountain streams offered ideal breeding places for the *anopheles minimus*.

As the Road pushed its way over the mountains and dropped into the Hukwang valley, the survey teams found in the dense virgin tropical forest not only the *minimus* but also its dread runner-up, the *anopheles leucosphyrus*. One of the reasons that the Hukwang valley has remained uninhabited is because of the prevalence of these two species. Yet along this route the Americans forged an all weather road and fought their battles against the Japs.

New problems were encountered in the rice paddies around Myitkyina and the swamps, large depressions, and innumerable shell holes—perfect breeding places—around Bhamo.

Drainage and Paris Green and oil sprays to prevent breeding were not enough. Sprays to kill the mosquito itself and screening and netting were necessary as a barrier between the mosquito and the soldier's skin.

Aerosol bombs—ingenious metal cylinders containing pyrethrum and freon—12—were used. Emitting their mist in the mosquitos' direction, they meant instant death for the mosquitos. Their compactness offered convenience and effectiveness for field units which could not be burdened with massive equipment. The contents of one aerosol bomb equal a gallon of liquid spray.

Millions of yards of hessian cloth—a type of burlap made from Indian jute—was used to combat the mosquito menace. With the help of native labor, it was used to line loosely woven bamboo bashas, tents, and bombed buildings used temporarily as Army billets. Everything was mosquito-proofed. Whenever fast moving troops stopped for a breather, the work began.

Troops engaged in combat and in the building of the Stilwell Road could derive only limited benefit from these more or less stationary measures. Each man was ordered to take certain recognized precautions himself. Wrists and ankles were covered at

night, and liquid repellent (dimethyl-phthalate) was spread on hands and face at night.

Even in the forward areas, troops saw regular movies. Areas were enclosed and attendants were instructed at the gate to apply their repellent before gaining admittance. One application was effective until the men could get under their nets for sleeping.

The Army manuals say that camp sites should be chosen some distance from the native population. But labor was needed, transportation was limited or non existent, and time was valuable; so the soldiers had to live in close proximity to the small native centers of population. Native huts and entire villages were sprayed with liquid insecticide.

Late in 1944, the India-Burma theater began to receive quantities of the new wonder chemical—DDT (dichloro-diphenyl-trichlorethane). It was a substance which would retain its killing power for several months once applied to a surface. It was possible now to use it in the native villages and habitations which had always constituted a major menace as reservoirs of infection. To cover large areas, DDT was sometimes sprayed from planes.

These measures had the mosquito on the run—for permanently situated individuals. But the one big weak link in all control measures is the person who moves in and out of an area, who doesn't stay put, who is cautious part of the time and careless the rest.

Atabrine, one of the wonder drugs of the war, provided the near solution to this problem. Malariologists in India and Burma declare its value far exceeds that of quinine in fighting malaria. Even if unlimited supplies of quinine were available, it is doubtful that the drug would be used in any quantity.

Atabrine doesn't prevent a person from contracting the benign type of malaria, but will suppress it so that he doesn't suffer from its effects. It usually does prevent malignant malaria.

Great strides have been made since Col. Rice began the pioneering job of stamping out malaria in the worst area in the world. It hasn't been stamped out completely, nor will it be until control measures are universally adopted. But the rate for American troops has dropped below all previous hopes, and there's every reason to believe it will continue to decrease.

Col. Rice has moved out of Assam to Ceylon, where for the past seventeen months he has served as medical adviser to Lord Louis Mountbatten, supreme commander of the Southeast Asia Command.

The malaria fight at present in India-Burma is being carried on under the direction of Colonel Karl R. Lundeberg, chief of the preventive medicine section in the theater surgeon's office. A native of Kenyon, Minn., Col. Lundeberg was recently awarded the Legion of Merit for his work in preventive medicine in the Surgeon General's Office.

Direct staff supervision of the control fight is handled by Major Maurice Seltzer, of Philadelphia, Pa. Malarialogists in each of three districts in the India-Burma theater coordinate the activities of malaria units, both survey and control.

These highly trained technicians have worked with the troops and ahead of the troops, in combat, on the Stilwell Road, through the jungles, in and around all types of installations. Theirs has been a major contribution to ultimate total victory. Without them, the Stilwell Road might never have been built and the battle for northern Burma might never have been won.

## Captain Mozzer Wounded

Captain Alexander J. Mozzer, AUS, of Manchester reports that he has been awarded the Purple Heart Medal. Captain Mozzer was wounded March 28, 1945 in the Philippines and is being evacuated to the United States.

## Promotions — Changes of Station

Warren T. Brown of Woodbridge and Victor G. H. Wallace of Darien have been promoted from Major to Lieutenant Colonel, Medical Corps.

Timothy F. Brewer, Hartford, has been commissioned a Lieut. Cmdr. and has been assigned to the Naval Hospital at Shuemaker, California.

Major W. B. Koufman, Windsor Locks, has been promoted to a Lieut. Colonel.

Charles C. Montano, Surgeon, USPHS(R) of Hartford has been appointed medical director of the Coast Guard for the Seventh Naval District with headquarters at Miami, Florida.

Lieut. Cmdr. William R. Wilson, New Haven, has been promoted to Commander.

## Army Doctors in War Zones to Get Assignments in U. S.

Major General Norman T. Kirk, Surgeon General of the U. S. Army, in a message appearing in the May 19 issue of *The Journal of the American Medical Association,* says that it will be the policy of the Army Medical Department to bring back to the United States medical officers relieved from service in the theaters of operations and to assign them on their return, as long as needed, to service in their specialties in American hospitals and other installations. These men will replace physicians with similar qualifications who have not had an opportunity for foreign service.

"This information," *The Journal* says editorially, "will answer the questions of many medical officers, some of whom have written and telegraphed to the headquarters of the American Medical Association asking for a defiinte statement on this subject." Continuing, *The Journal's* editorial says:

"Many physicians have also written to the American Medical Association protesting against the possibility that they may be assigned on their release from service with the armed forces to the Veterans Administration. These letters were brought before the Committee on Post War Medical Service at its meeting in Chicago May 12. That committee took prompt action, adopting the following statement, which was sent to the Secretary of War, Secretary of the Navy and the Committees on Military Affairs of the House of Representatives and the Senate:

" 'In November 1944 the Army Medical Department was directed to transfer at least 300 medical corps officers to the Veterans Administration, this number to include those officers in the zone of the interior who were formerly employed by the Veterans Administration as civilians. Apparently about 100 men meeting the latter classification were so assigned and in addition some 200 others selected largely from among men who had been marked "limited service." Many of those thus assigned have protested and others are now protesting bitterly against these assignments on the ground that their enlistment was distinctly for military service and that assignment to the Veterans Administration cannot be thus characterized. Many physicians who have served with distinction in both the European and the Pacific theaters of operation are now indicating by communications addressed to the headquarters of the American Medical Association the fear that they may be assigned on their return to the United States to service with the Veterans Administration. The unwillingness to serve with the Veterans Administration is based not only on their belief that this cannot be considered military service but also on the point of view that competent, scientific medical care is difficult under the conditions that prevail in the veterans' hospitals.

" 'The Committee on Post War Medical Service which includes representatives of the American Medical Association, the American College of Surgeons, the American College of Physicians, the American Hospital Association, the Federation of State Medical Licensing Boards, the Association of American Medical Colleges, the Catholic Hospital Association, the Advisory Board for Medical Specialties and many other groups, after careful consideration of the problems involved urges that the Secretary of War, the Secretary of the Navy and all others concerned with the activities of physicians voluntarily enlisted in the armed forces recognize the righteousness of the protests made by these medical officers against assignment to the Veterans Administration. It is further urged that the needs of the Veterans Administration for physicians be met either by voluntary enrollment of men in the armed forces at the time of their release from the service or by recruitment of medical personnel from civilian sources.'

"The American Medical Association—and this statement is made wholly in explanation of a fact that should be obvious to every one—does not have authority to determine in any way the assignments of physicians in the armed forces. The officers of the Association would be hesitant to interfere in the making of decisions as to the assignments or transfer of men in the armed forces. The decisions as to how military personnel are to be utilized must rest with those who carry the responsibility for the ultimate results. This statement is made because many a medical officer has written to the headquarters of the American Medical Association actually demanding that the Association exert its influence to determine the decisions, not only of those responsible for the medical departments of the armed forces, but even of the Secretaries of War and Navy, of the Committees on Military Affairs of the legislative bodies and even of the President. The Board of Trustees and the officers of the Association have felt keenly, nevertheless, the responsibility that rests on them to present to those in authority the facts that should be given serious consideration in the making of decisions concerning medical personnel.

"Unfortunately, steps have not yet been taken by the Selective Service System for a continuing supply of physicians for the future. The medical schools are confronted at this moment with an insufficient number of men to fill their freshman classes in the years immediately to come. The Committee on Military Affairs of the Senate, having given serious and extended hearings to the Ellender bill, has failed to issue a statement of its reaction to that proposal. The time may yet come when those with the authority and the responsibility will have to answer to the people of the United States for a critical situation in the supply of medical service."

## Acting Secretary of War Patterson and General Kirk Report on Health of Army

In presenting Major General Norman T. Kirk, Surgeon General of the Army, at the Secretary of War's press and radio conference on 24 May 1945, the Honorable Robert P. Patterson, Acting Secretary of War, said in part:

The war in which we are engaged has produced many seemingly unsurmountable problems, problems without precedent in the development of new weapons, new methods of training, and new tactics. But none of these problems has been more difficult than the problems faced by our Medical Department in caring for the largest American Army in history, fighting in virtually all parts of the world. And yet, despite these problems, no Army at any time in history has achieved a record of recovery from wounds and freedom from disease comparable to that of the American Army in this war.

The Medical Department, its doctors, its nurses, its corpsmen, has saved the lives of 97 out of every 100 men wounded in battle who reach a hospital, compared with 92 in the World War. Seventy out of every 100 wounded overseas were returned to duty, and 27 were evacuated to this country.

During the past three years, the Medical Department has maintained a record of less than one death from disease per 1,000 men per year. During the World War, 19 out of every 1,000 men died each year from disease. During the Spanish-American War we lost 26 out of every 1,000 per year, and in the Civil War, 65 out of every 1,000 men died each year from disease.

In all, during this war, 12,000 men died from disease from December 7, 1941, to May 1, 1945. In World War I, 62,670 men died from disease; in the Spanish-American War, 3,500 died from disease, and in the Civil War, 336,216 men of the Union and Confederate armies died from disease.

Malaria has been reduced from hundreds of cases per 1,000 men per year to less than 50. The dysenteries, which once put entire regiments and armies out of action, have occurred among less than 90 out of every 1,000 men per year and have been readily controlled. During World War I, 38 per cent of the men who contracted meningitis died, compared with 4 per cent in the present war, and 24 per cent of those who caught pneumonia died in 1918 compared with only seven-tenths of one per cent in this war.

No greater tribute can be paid to the Medical Department of our Army than the tribute paid by its record of saving lives in this war.

It is a record written by Medical Corpsmen following the troops into battle; by doctors performing their surgery amid the bursting of bombs; by the self-sacrifice of American women in the Nurse Corps, laboring long hours under the most difficult of conditions, by thousands of other Medical Department personnel, and by scientific research and development.

The Medical Department today is well prepared for the intensification of its work brought about by the cessation of hostilities in Europe. Thousands of wounded veterans in the European and Mediterranean theaters are being transported to the United States as fast as ships and planes are available. Physical examinations are being given to each of the 3,500,000 soldiers in those theaters before they are redeployed. And Medical Department personnel will be sent to the Pacific in ever increasing numbers as our forces are marshalled for the final blows against Japan.

The peak of the Medical Department's activities will not be reached until the fall of 1945. At present wounded and sick are being returned to this country from all theaters at the rate of 44,000 a month. This evacuation will continue until all of the patients in the European and Mediterranean theaters are removed, which will require 90 days.

In anticipation of this movement of patients from Europe to this country, the Army has provided seven additional hospital ships, three of which are now in service, with four more to be commissioned shortly. This will bring the total number of hospital ships to 29, with an aggregate patient capacity of 20,000. Of the 25 Army hospital ships now in operation, 18 are in the Atlantic, five are in the

Pacific, and two more are en route to the Pacific.

In addition to these hospital ships, special hospital equipment has been placed aboard 24 troop transports, giving the Army an additional patient-carrying capacity of 40,000.

Eight thousand patients a month are being brought back to the United States by plane, with three-fourths of this air traffic over the Atlantic.

The arrival of these thousands of wounded and sick in this country during the next three months will place a heavy load on our General and Convalescent hospitals. The population of all Army hospitals in the United States at present is 290,000. By September, this is expected to reach 315,000, taking into consideration the discharge rate.

It can readily be seen that the Medical Department will be operating at capacity for many months to come and there will be a critical need for its professional and civilian personnel during this period.

General Kirk's statement follows:

"The Army Medical Department is well prepared to maintain its record of saving lives and guarding against disease in the second phase of World War II which will be centered in the Pacific. As combat activities increase in that area troops moved from European theaters will find a different type of warfare, different diseases and different methods of combatting disease.

"The Medical Department has been preparing for years for its fight on disease in the Pacific. In addition to its intensive research into diseases common to that area it has gained much value in practical application of its methods from the campaigns already fought.

"In the Pacific areas our fighting men are exposed to many types of disease that are rare in the United States and Europe. However, this should not be considered cause for alarm. With proper preventive measures and medical service the disease rate in the Pacific will be kept to a minimum.

"Every fighting unit in the Pacific area has had the same type of medical organization accompanying it as those in other theaters. The chain of evacuation of the wounded is well organized and is very effective. Because of geographical and climatic differences certain changes were desirable, but the same high type facilities are available.

"The main diseases to be encountered in the Pacific are malaria, the dysenteries, scrub typhus, skin infections, schistosomiasis, filariasis and dengue fever. Excellent progress has already been made in keeping the incidence of all of these diseases to a very low degree.

"Malaria, for example, has been reduced to one-fourth its incidence in the early part of the war so that the overall death rate from malaria in the Army is .01 per cent.

"The use of DDT and atabrine is primarily responsible for lowering the incidence rate of the most disabling tropical diseases. The remarkable record in lowering the malaria rate is due also to strict discipline and control measures. Malaria is spread by the anopheles mosquito. DDT, a recently developed insecticide, is used to kill this mosquito and the larva. Areas are sprayed with DDT by plane and a five per cent solution of DDT sprayed on barracks walls in kitchens and huts kills all mosquitoes and flies alighting thereon for months after spraying.

"The dysenteries, so common in the Pacific areas, which are spread by flies are also rendered less prevalent by the use of DDT.

"Atabrine has been found more effective as a therapeutic agent in the control of malaria than quinine.

"Filariasis, which is also spread by the mosquito, is reduced by the use of DDT and mosquito control methods.

"Schistosomiasis is caused by a small fluke found in pools and running streams which in a matter of seconds burrows through the skin and infects the individual. All water found to contain these flukes is posted and personnel is warned not to bathe, wade or wash in it.

"Areas found to contain scrub typhus are immediately burned over, clothing is impregnated, and efforts are being made to develop a vaccine to counteract it.

"Dengue fever, also spread by the mosquito, is controlled by the use of DDT and mosquito abatement.

"It can readily be noted that DDT is one of the miracle developments of this war.

"Last year a tropical disease center was opened by the Army Medical Department at Moore General Hospital, Swannanoa, North Carolina. It was designated as a center for the study and treatment of tropical diseases. This center has assisted greatly in the investigation and treatment of these diseases and

has reduced the loss of manpower as a result of illness, thereby making an important contribution to the continuing improvement of American medicine.

"In addition to protecting the soldier from diseases of the tropics the Army Medical Department is affording all possible protection against disease and harmful pests which might be brought into the United States by military traffic. This is done through a quarantine branch which works in conjunction with the U. S. Public Health Service and the Navy.

"The Army program includes measures to prevent the importation of dangerous insects from abroad. Extensive insect control programs have been carried out about military stations and airports abroad, using highly effective techniques and agents. Passengers, planes, ships and cargo are sprayed with insecticides in order to eliminate insect risk.

"The battle is also waged through the control of rats and vermin. The most effect means of ridding ships of rats has been to build ships in such a way that rats cannot live or breed aboard them. Modern American ships are practically free of this age-old problem.

"To protect the country against agricultural diseases and pests which might be imported, rigid restrictions and inspections are made fully effective for military traffic. Particular stress is laid upon packing materials which might harbor insect forms.

"The Army Medical Department has complete medical and sanitary surveys of all the territory in the Pacific which is potential battle ground. The health hazards to soldiers are known to the Medical Corps officers who accompany all invasion troops and that knowledge is distributed to all the men.

"The Army Medical Department has been doing a fine job in the Pacific and will continue to do that job as activities in that theater increase. It is true that the pestilential islands of the Pacific have not been changed into gardens of Eden, but when the deplorable health conditions that existed there are compared with what has been accomplished it is obvious that our victory over the Japs will be hastened.

"While all of this work and planning was going on for the increased activity in the Pacific the Army Medical Department during 1944 took care of 4,435,000 patients in hospitals—2,315,000 in the United States and 2,120,000 in hospitals overseas. In addition it provided care for an additional 43,210,000 non hospitalized patients—those with minor infections and injuries who were only temporarily incapacitated.

"It performed the essential functions of caring for men wounded in battle, the injured and the sick to maintain fighting strength with 45,000 medical corps, 15,000 dentists, 52,000 nurses, 2,000 veterinarians, 18,700 medical administrative corps men, 2,500 sanitary corps specialists, 1,000 physical therapists, 1,500 dietitians, 61 pharmacy corps officers, 535,000 enlisted medical aid men and approximately 80,000 civilian employees.

"Illness and recuperation of wounded and injured men does not cease with a formal declaration of the end of hostilities on any front. The care of these men and women is a continuing responsibility of the Medical Department which will go on for many months in the future. It will increase rather than diminish during the remainder of 1945, acording to the best estimates which can be made now. Therefore, as I have said before, medical care by the Army has yet to hit its full stride. One thing I wish to promise is that the best scientific medical attention will continue to be furnished to every man needing it."

## Surgeon General Outlines Personnel Release Policy

Substantial releases of Army Medical Department personnel will not take place before the latter part of this year, Surgeon General Norman T. Kirk said in announcing a policy on discharges in conformity with War Department procedures. This is due to the fact that the peak of the Medical Department's activities will not be reached until fall.

In formulating the policy consideration was given to civilian needs for professional medical, dental and veterinary care without weakening military needs. Other factors considered were the length of time necessary for personnel to complete their work in the Mediterranean and European theaters and return to the United States; replacement of Medical Department personnel in active theaters by those who have not had overseas duty; necessity for the maintenance of a high standard of medical care; the heavy load of patients in the United States; evacuation of the sick and wounded from Europe in the next ninety days and continuing medical service in the Pacific.

The policy applies with equal effect to Army

medical officers assigned to the Veteran's Administration and other agencies.

It reads:

MEDICAL CORPS

a. Officers whose services are essential to military necessity will not be separated from the service.

b. Officers above 50 years of age whose specialist qualifications are not needed within the Army will receive a high preferential priority for release from active duty.

c. Adjusted Service Ratings will be utilized as a definite guide to determining those who are to be separated.

## Free Medical Care for British School Children

The British Information Services have just released the following statement relative to school medical services in Great Britain: "Since April 1, under the provisions of the new Education Bill, comprehensive facilities for free medical treatment—other than that given in the home—are available for children attending all primary and secondary schools maintained by public funds. At present the administration of this provision is in the hands of local authorities until such time as the National Health Service begins to function. Under wartime conditions this service is necessarily limited. Local authorities are advised by the Minister of Health to concentrate on developing clinic facilities for the present. The school medical service covers treatment of minor ailments, diseases of the ear, nose and throat and defective hearing, diseases of the eye and defective vision, orthopedic and dental treatment, child guidance, speech therapy, and the treatment of rheumatism. In rural areas school authorities may arrange with general practitioners for the treatment of pupils referred to them by medical officers. The enlargement of these services will follow the peace as soon as personnel is available."

### DDT STUDIED FOR OUTDOOR USE HERE

Extensive investigations are now being conducted to determine the benefits and possible hazards involved in the contemplated use of the insecticide DDT on a large scale outdoors as part of a plan to control insectborne diseases.

In the Pacific Theater, DDT proved highly valuable in bringing insectborne diseases under control. However DDT will not be employed indiscriminately in this country until more research work has been completed on the general biological effects of this insecticide.

Besides killing insects that carry diseases, DDT may kill other insects that are beneficial—and thus affect the balance of nature which is important to agriculture and wild life. In combat zones, where the health of the soldier was at stake, it was necessary to ignore these considerations but in the United States general outdoor applications will not be adopted until more is known about these biological effects.

### CAPTURE LARGEST NAZI MEDICAL SUPPLY DEPOT

Germany's largest military medical supply depot at Ihringhausen fell into American hands recently when the 80th Infantry Division captured Kassel. According to the Division Surgeon, Lieutenant Colonel Harold J. Halleck, MC, of Winamac, Ind., it contained $100,000 worth of new surgical instruments of excellent quality, vast stores of pharmaceutical supplies and complete facilities for the production of pills, medical capsules, vials and precision instruments. Nearly 4,200 gallons of wood alcohol were found buried there.

The first Army Medical officer to enter the depot, Captain Henry J. Meyer, MC, of Minneapolis, Minn., said that in strict observance of the Geneva Convention, the German medical personnel left the plant and all medical supplies undamaged. All bacteriological cultures and disease inoculated animals in the adjoining experimental laboratories had been destroyed prior to capture.

The plant and supplies will be used by the Army Medical Department to ease the drain on our own supplies by captured German military and civilian hospitals.

### BRITISH GRATEFUL FOR "DEVOTED CARE"

Surgeon General Norman T. Kirk has received a copy of a formal letter of appreciation written by Lieutenant General G. N. MacReady of the British Joint Staff Mission, on the liberation of British prisoners of war in the Philippines. General Sir Ronald S. Adam, Adjutant General to the Forces is quoted in the letter as stating that all British prisoners liberated from Cabanatuan and Bilibid "speak in glowing terms of the devoted care given to them by American troops after their release, as well as of the excellent administrative and medical arrangements made in the S. W. P. A. and U. S. A. for their homecoming." The letter conveys "the deep appreciation and warm thanks" of the British Army Council to all concerned.

## War Medicine: Vol. 7, No. 3, March 1945

This issue contains two articles dealing with the complications arising from high altitudes. One of these by Major A. F. Goggio and Lieut. Col. G. H. Houck, MC—AUS, discusses the physiologic abnormalities and pathologic changes following exposure to simulated high altitudes. The other by a group of medical officers of the Army discusses the effects on the brain and nervous system from high altitudes. These authors found but 0.28 per cent incidence of

reaction with symptoms referable to the nervous system and emphasized the fact that there seems to be no one portion of the nervous system more resistant or more vulnerable than another to the effects of simulated high altitude with mild anoxia.

Two articles on penicillin appear. One of these concerns itself with the stability and activity of this mold in solution and in ointment, the other outlines the penicillin program at the U. S. Naval Hospital, Portsmouth, Virginia. The summary of the efficacy of penicillin in the various infectious disease processes is very interesting and should be a valuable index to physicians.

The remaining articles have to do with (1) the influence of crowding on respiratory illness in which a group of Naval medical officers and their assistants conclude that the number of men in a room and not the floor space or cubic space allotted each man governs the amount of respiratory illness; (2) a psychiatric study of 100 AWOL prisoners in the Army; (3) acute heart failure following "blast injury" in which digitalization and venesection are advocated to combat pulmonary edema; (4) a report of three cases of visceral leishmaniasis in the Army; (5) the sweat pattern; and (5) healing of wounds in New Guinea. The twenty-five pages of abstracts from current literature are taken chiefly from English and American journals. There are two book reviews.

## War Medicine: Vol. 7, No. 4, April 1945

The April issue contains two psychiatric articles discussing the use of the Cornell Service Index, one in assaying personality and psychosomatic disturbances in men in the Armed Forces, the other in the evaluation of psychiatric problems in a naval hospital. Two USNR psychiatrists discuss the program followed in selecting naval personnel. Two articles on nutrition appear. In one Dr. Robert E. Johnson of Boston describes the development of a self contained traveling nutritional laboratory, practical even under primitive conditions. The same author with three others gives a detailed account of the method used in assessing the nutritional status of young men active in the field.

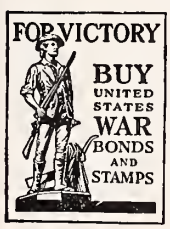
Bulletin TB-Med. 147, prepared for the Surgeon General's Office by the Surgeon Consultants Division, is printed in this issue. It comprises notes on the care of battle casualties and reflects the opinion and practice of surgeons working throughout the battle zones.

Twenty-five pages of abstracts from current literature and two book reviews complete the issue.

## Penicillin in Tablets

Stealing the march on U. S. producers of penicillin, who must await lifting of the WPB restrictions before they can begin producing the drug in pills and ointments for commercial use, the Mexican government has granted permission to its sole commercial producer, Wyeth-Stille, S. A., of Mexico City, affiliate of Wyeth Incorporated, to go ahead and make penicillin in tablets available for civilian use immediately. In less than three weeks the company changed over its production of penicillin from the injectable sodium salt type to the calcium salt tablets, now on sale. The tablet is packed in vials containing five tablets of 20,000 units each. The vials contain a desiccant which absorbs moisture, allowing the penicillin to remain stable for six months or more, it is claimed.

A second oral penicillin, not in tablet form, but one which may be administered by mouth with as much comfort as the tablet and without affecting the reaction of the blood towards either the alkaline or acid side is in the process of manufacture. The buffer solution in the new oral penicillin, which is employed to protect the penicillin against the action of the gastric acids in the stomach, is an ampholyt, alumina hydrate gel, which is neither acid nor alkaline. The new oral product is given with one ounce of water at four hour intervals, and will cure a case of gonorrhea in 36 hours.




MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## THE SHIP OF STATE

CONNECTICUT'S lawmakers have left for their cities, towns and farms, the corridor conferees have dispersed, the Senate and House chambers are once again serene. At 4:00 o'clock on the morning of June 7, the 1945 General Assembly adjourned after five months marked by strife and dissension between the Democratic controlled Senate and the Republican House and within the ranks of both parties.

The Legislature during the months past has been used for a whipping-boy with even more than the customary enthusiasm. Censure and reproval have frequently given way to opprobrium and invective. Republicans and Democrats have been flayed collectively and individually for their unequivocal partisan stand on many matters. It appeared at times that the bitter contest over the division of patronage had entirely obscured the press of other legislation. The situation did, in fact, become so acute that hundreds of bills were still on the calendars for the last two days and the fate of many remains even now uncertain after the frenetic confusion of the closing hours.

The disappointment and vexation prevailing in many quarters over the actions of the General Assembly happily need not extend to persons concerned with medical care and health. Several measures of import for the health and welfare of the people of Connecticut have reached the Governor's desk, after a rough journey in some cases, and their addition to the General Statutes seems probable.

There was wide interest around the state in the establishment of a program for the care of the chronically ill and the prospects of H144, a bill to initiate such a program varied from week to week. On the evening of the final day, however, this bill which is entitled An Act Creating a Commission on the Care and Treatment of Aged, Infirm and Chronically Ill People of the State was approved by the Senate after passage in the afternoon by the House. The appropriation of $100,000 which the measure originally carried had been reduced to $25,000 and in all likelihood this sum will be expended by the commission of seven members to continue study of the problem, with the objective of recommending to the next Legislature a large appropriation for the expansion of existing facilities or the acquisition of new ones.

A committee bill, H1194, providing for the institution of a state plan for mental health, was brought safely through both chambers after the earlier rejection of H1063 and H602 which did not differ materially from it. Under the stipulations of H1194, each state hospital for mental illness is directed to establish psychiatric clinics for adult persons, the state training schools at Mansfield and Southbury are to establish clinics for retarded persons or those suffering from epilepsy and the State Department of Health is to expand its program of psychiatric clinics for children. Furthermore any general hospital in the state may apply to the State Department of Health for funds to be used to establish a psychiatric service and will be granted such funds if the plans for the service are approved. The appropriations included in the defeated bills were here eliminated but the necessary expenditures will be covered by the budget.

The long struggle of the state-aided hospitals of Connecticut to obtain an increase in the payments for the care and treatment of various beneficiaries under the terms of Chapter 99b was at least partially successful this year. The requested rate of six dollars per day for these cases was cut to four in the Appropriations Committee but this amount, while not fully adequate, is nevertheless a step toward approximation of the actual cost of care to the institutions. The new per diem rate will not affect the subsidies which the state grants to the hospitals.

There is cause for some satisfaction also in the selection for passage from the welter of bills relating to liquor control of two which may have important implications for public health and medicine. One of these, H406, creates a board to study the problem of alcoholism in Connecticut and establishes an experimental pre-sentence court clinic for inebriates. This board of five members appointed by the governor is charged with the responsibility of evaluating and reporting on the efficiency of a pre-sentence clinic in 1) aiding the courts in their disposition of drunkenness cases and 2) selecting those types of alcoholics most suitable for rehabilitation. The second bill, S713, allocates a portion of the revenue obtained from taxes on liquor for the study, treatment and care of alcoholics. It should be noted in this connection that S32, An Act Establishing a State Hospital for Inebriates, which was vigorously opposed by many authorities in this field, appeared to have an excellent chance for passage but was ultimately rejected on June 2.

H999, the act which empowers the Connecticut Hospital Service, Incorporated, to enter into contracts with and act as agent for medical service corporations, was followed with interest by physicians and others concerned with the problem of payment for medical care. When this bill is signed by the governor, the prepayment plan sponsored by the State Society will become an actuality after several years of careful study and unremitting work by the various committees on Prepaid Medical Care and other members. With signature virtually assured, the subscriber's contract and certificate of incorporation are in preparation and it can be predicted that this undertaking of great consequence for the Society will be launched by Fall.

In a previous summary of the progress of affairs on Capitol Hill, reference was made to the numerous and articulate opponents of H1031, An Act concerning Examining and Licensing Boards and Commissions and Establishing a Department of Professional and Vocational Licensing. This measure, proposing the consolidation of twenty-one examining and licensing boards to form a department of licensure under the direction of a commissioner, was obviously an ill conceived and unsound piece of legislation. Along the way, a substitute bill directing the Legislative Council to make an investigation of methods and procedures employed by the various examining and licensing boards was introduced and this bill was passed. An investigation of this kind, provided that it is detailed and thorough, may yield instructive data and is in any case a prerequisite to changes in present licensing practices.

S83 and S84, introduced at the request of the State Medical Society, were not controversial in any respect and both bills were passed. S83, An Act concerning the Healing Arts, changed the wording of one sentence of Section 2740 in such a manner as to prevent appointment of graduates of unapproved medical schools to internships in Connecticut hospitals. S84 amends the charter of the Connecticut State Medical Society to provide for the participation of certain additional members of the Council of the Society as members of the House of Delegates.

A number of other bills bearing on health and welfare await only the approval of Governor Baldwin. These are not of uniform merit but the majority are at least worthy of brief mention.

S114 provides that the clerk of the court must notify the State Department of Health when any person practicing midwifery is convicted of a crime.

S121, An Act concerning Actions for Injuries Resulting in Death, has significance for physicians because it raises the limit of recovery of damages in fatal cases to $25,000.

By the passage of S129, only licensed physicians, osteopaths or dentists are permitted to use Roentgen-rays, x-rays or radium for therapeutic or cosmetic purposes.

S130 amends the General Statutes to provide for state payment of costs of hospital care and medical treatment of suspected typhoid and paratyphoid carriers as well as for proved carriers.

S288 authorizes the combination under one management of all the property and activities of the Grace Hospital Society and the General Hospital Society (New Haven Hospital) and thus clears the way for the establishment of the Grace-New Haven Community Hospital.

The probate courts are made responsible for the commitment to isolation hospitals or other suitable institutions of recalcitrant tuberculosis patients by S755. Under the present statutes, health officers or boards of health have had the task of following through on these cases and in many instances have been unable to prosecute them successfully.

H193 adds isonipecaine (Demerol), a drug already covered by the Harrison Act, to the list of narcotics in Section 970c of the 1935 supplement to the General Statutes.

Under H323, sheriffs are empowered to choose a physician to examine mentally ill prisoners and are authorized to provide for payment of expenses of temporary hospitalization.

H400 limits the use of the title "Certified Psychologist" to psychologists examined and licensed by a commission to be appointed by the governor from a list submitted by the Connecticut Psychological Association.

Patients in mental hospitals are permitted by H811 to remain on parole with relatives, etc., for one year instead of six months and H814 gives legal status to the joint committee of the state mental hospitals and training schools which has been functioning on an informal basis for some time.

The sum of $25,000 is appropraited under H1109 for expenditure in the provision of maternity care for wives of men in the armed services.

Barbituric acid derivatives are added to the list of prescription drugs which may not be refilled except on order of the physician by H1206. Although physicians and pharmacists have cooperated well in preventing the indiscriminate purchase of barbiturates, it is desirable to incorporate this provision in the statutes.

On the other side of the slate are the proposals which were rejected by the Senate and House or which were not reported out of committee and died. It is gratifying to find that these were preponderantly bills which were, from the medical and social points of view, potentially harmful or at least not constructive. The failure of the Legislature to approve certain bills, however, seems unfortunate and short-sighted and this applies particularly in the case of H617, An Act Providing for a State Hospital Survey. This act was introduced in order that Connecticut might receive the benefit of Federal funds, which will be allotted as grants-in-aid if S191, the Hill-Burton hospital survey bill now pending in Congress is passed, in making a survey of existing hospitals to evaluate their sufficiency and to determine additional needs. As far as can now be learned, this measure was not reported out of the Appropriations Committee after its referral there. It will indeed be regrettable if our state is to lose this opportunity to obtain financial assistance in making a necessary and productive study.

The rejection of H191 and H196 is likewise disappointing to many persons. H191 would have appropriated funds for the construction and equipment of a building for the State Department of Health, the bureaus of which have long been separated and housed in inadequate quarters. H196, the district health department bill defeated in several past sessions, permitted two or more towns, cities or boroughs to unite to form a district board of health in order that resources for the maintenance of health might be combined. Connecticut's smaller towns continue to fight any measure which they consider a threat to their autonomy.

H580, which proposed a precise definition of mentally ill persons, instead of the present inaccurate and confused one in the statutes, was rejected for reasons which are not clear but were probably trivial.

There will be some who will note with relief the rejection of H847, an act which would have increased the requirements for admission to examination for osteopathic licensure and would have permitted licensed osteopaths to withdraw blood for prenatal serological tests and make and file reports and certificates necessary in the control of communicable diseases. The Society, however, did not oppose the measure and the majority of physicians presumably did not object to it.

It is fair to assume that the profession as a whole did not favor the passage of H593, the hotly contested bill which would have lowered the requirements for admission to examination for licensure as registered pharmacist. The proponents of this bill did not relax their efforts for approval until the last minute and it was twice voted down in the Senate, after rejection in the House, by only a narrow margin.

The rejection of S361, An Act concerning Trained Attendants, was well advised since the bill would have permitted certain employees of industrial establishments and veterans to be licensed as trained attendants without examination or fulfillment of present educational requirements. The Society's Committee on Industrial Hygiene was active in opposition to the proposal.

H451 was also an unfeasible measure providing for the appointment of a board which would be responsible for the examination of all persons about to be committed to hospitals for the mentally ill. While the theoretical value of such examination by a board of qualified persons is not questioned, the practical operation of the law would present well nigh unsurmountable difficulties.

Three bills to prevent the sale of unpasteurized milk and cream were defeated, to the surprise of no

one. The measure to establish a social protection commission, H440, was killed as were H1000, an act permitting natureopaths to withdraw blood for dagnostic purposes and H1055 which proposed the initiation in industrial plants of methods and devices to protect the hearing of employees.

S754, An Act concerning the Establishment and Administration of a System of Health Insurance, has been competently analysed in a previous issue of the JOURNAL. The last news heard on this ambitious and extravagant bill was a favorable report of the majority of the Senate members of the Appropriations Committee. It was a frankly partisan matter and unless it was resuscitated in the early morning hours of June 7, it is moldering in its grave where it should be.

Reliable information on the disposition of other bills of pertinence to medicine and the public health is not presently available from any source. The state of affairs before adjournment was such that in all probability many of the members of the Legislature do not know what was passed and what rejected. Progress in a particular area, rather than the overall accomplishments of the 1945 General Assembly, is here under consideration. On the basis of the record in this field, it appears that the Legislature made some contribution to the public good and cannot be indicted on as many counts as have been commonly charged against it.

## NEWS FROM WASHINGTON

### More Physicians For Civilians

On Tuesday, June 12, Senator Downey of California introduced the following resolution (S. Res. 134) which was referred to the Committee on Military Affairs. Senator Downey hears that there may not be an adequate number of physicians to meet the post war needs and feels that steps should now be taken to meet the great demand that there may be. He considers this matter of such importance that he will press the Military Affairs Committee for immediate action on his resolution.

"Resolved, That the Committee on Military Affairs, or any duly authorized subcommittee thereof, is authorized and directed to make a full and complete investigation with respect to the relative needs of the armed forces and the civilian population for the services of medical personnel with a view to ascertaining (1) whether, as a result of developments in the war, or through more efficient utilization of medical personnel, such personnel can be released from the armed forces for civilian service without impairment of the war effort; (2) the speed with which demobilization of medical personnel in the armed forces can be accomplished as the needs of the armed forces diminish, and (3) whether any further action is necessary to insure an adequate supply of trained medical personnel to meet the future needs of the armed forces and the civilian population of the Nation. The committee shall report to the Senate at the earliest practicable date the results of its study and investigation, together with such recommendations as it may deem desirable.

"For the purposes of this resolution, the committee, or any duly authorized subcommittee thereof, is authorized to hold such hearings, to sit and act at such times and places during the sessions, recesses, and adjourned periods of the Seventy-ninth Congress, to employ such clerical and other assistants, to require by subpoena or otherwise the attendance of such witnesses, and the production of such correspondence, books, papers, and documents, to administer such oaths, to take such testimony, and to make such expenditures, as it deems advisable."

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### Adm. Stephenson Named to Head Cancer Society

Appointment of Rear Admiral Charles S. Stephenson, of the United States Navy, retired, as acting managing director of the American Cancer Society, to succeed Dr. Clarence Cook Little, was announced recently by the executive committee at a meeting in the society's offices, 350 Fifth Avenue.

Dr. Little, who has directed the society and the Roscoe B. Jackson Memorial Laboratory at Bar Harbor, Me., since 1929, will conduct studies of genetic factors of intelligence and emotional variations in mammals, for which a grant of $282,000 was recently made by the Rockefeller Foundation. He will continue direction of biological research on cancer and allied conditions.

Admiral Stephenson is a specialist in preventive medicine. He was director of the department of hygiene and preventive medicine of the Naval Medical School, and was advisory councilor of the United States Public Health Service and of the division of health and safety of the Tennessee Valley Authority. He directed the United States of America Typhus Commission, and was liaison officer of the division of medical sciences of the National Research Council.

# WOMAN'S AUXILIARY

## TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. James Raglan Miller, *Hartford*
*President-Elect*, Mrs. James Douglas Gold, *Bridgeport*
*First Vice-President*, Mrs. Creighton Barker, New Haven
*Second Vice-President*, Mrs. H. Bertram Lambert, *Southport*
*Recording Secretary*, Mrs. Charles W. Goff, West Hartford
*Corresponding Secretary*, Mrs. Edwin R. Conners, *Bridgeport*
*Treasurer*, Mrs. Julian G. Ely, Lyme

## ADDRESS OF THE PRESIDENT, MRS. H. BERTRAM LAMBERT

To Members of the Woman's Auxiliary to the Connecticut State Medical Society:

It is with a deep sense of gratitude that I submit this first annual report of the Woman's Auxiliary to the Connecticut State Medical Society. It has been an unusual privilege to serve this infant organization, to work for its firm foundation and steady development. The progress which has been made during the year must be attributed not only to the unceasing efforts of the officers, directors and committee chairmen, but especially to the splendid and stimulating spirit of interest, confidence and cooperation which every member has shown.

The Woman's Auxiliary to the Connecticut State Medical Society was organized on May 3, 1944, during the 152nd Annual Meeting of the Society. Mrs. Eben J. Carey, president of the National Auxiliary, in the principal address, explained the objectives of a Woman's Auxiliary and described some of the activities of the 41 State Auxiliaries then in operation. During the session, the officers and directors representing each county of the state were elected. A substantial personal gift to the treasury of the Auxiliary by the retiring president of the State Society, announced at the meeting, provided an encouraging start in our work. Secretarial assistance and other aid generously given by the Executive Secretary's office have been invaluable to us in our first difficult months.

Our efforts during the past twelve months have been largely concentrated on the organization of the entire state on a county basis. As permission was granted by each County Medical Association, the coresponding County Auxiliary was formed. Active groups are now operating in seven counties, and we are able to report a total of nearly six hundred members. This membership assumes greater significance in view of the fact that the State Medical Society has just over 2,000 names on its roster. The major share of the credit for this achievement belongs to Mrs. Creighton Barker, organization chairman.

The organization drive, which has demanded attendance at numerous meetings, both small and large, has been time consuming and has necessitated the postponement of many other activities which are planned for the future. The Auxiliary, did, however, undertake the preparation and mailing of a Christmas News Letter to the members of the State Medical Society in the Armed Forces. The response from our Connecticut physicians serving in every theater of war was so enthusiastic that the project has been turned over to the War Participation Committee and a second news letter is even now on its way. Keenest interest in any opportunity to contribute to the happiness and welfare of the men who are away from home is found throughout the Auxiliary.

At all meetings in this first year of our existence, stress has been laid upon the importance of a clear understanding of problems of health and medical care by the members of the Auxiliary. As one step toward this objective, several meetings have been devoted to discussion and explanation of bills concerning public health and medical care which are now before the Connecticut General Assembly. This Auxiliary is fortunate in having as its Legislative Chairman, Mrs. Edith Valet Cook, an attorney who has served in the Legislature and is active in social service and welfare work. National legislation will also be studied by each County Auxiliary with the aim of making each member not only a better informed physician's wife, but a more useful citizen.

The president of the Connecticut State Medical Society for 1944-1945 stated on several occasions that there were two objectives which he hoped to see accomplished during his term of office, the launching of a Building Fund drive to raise funds for permanent headquarters for the Society, and the organization of the Woman's Auxiliary. Both of

these objectives have been realized and the Woman's Auxiliary will have its own offices in the new home of the Society.

I should now like to tell you how much I have enjoyed the work and the great pleasure I have experienced in meeting such a remarkable group of women. It has been a wonderful year, and I want to thank you all for having made this possible. I sincerely hope that the same cooperation will be given my successor in office.

## Report of Annual Meeting, May 23, 1945

The annual meeting, held at New Haven Colony Historical Society, 114 Whitney Avenue, New Haven, was called to order by Mrs. H. Bertram Lambert, president, who greeted the members of the Auxiliary and introduced the guest speakers: Dr. Joseph H. Howard, president of the Connecticut State Medical Society, Mrs. David S. Thomas, president, Woman's Auxiliary to the American Medical Association, Dr. Ralph L. Gilman, chairman of the Advisory Committee, and Mrs. Benjamin P. Burpee, former president of the Woman's Auxiliary to the New Hampshire State Medical Society.

Dr. Howard greeted the Auxiliary members and congratulated them on the achievements of the first year. He stated that the Auxiliary is a partner to the State Medical Society in advancement of health education. Dr. Howard felt that the profession has lost touch with the public. Due to that, legislative bills are brought up with proposals to bring changes in the running of medicine. He felt that the professional group in each State should unite in facing these problems. New medical bills are not supported by labor groups only, but by many others. He felt it very important for the Auxiliary to familiarize itself with current bills, to be active in various organizations and be aggressive in a dignified manner. Dr. Howard also stressed the question of public relations and told of a recent meeting of 17 State presidents where the importance of radio programs on health was emphasized and urged the support of these programs.

As another method to reach the public, Dr. Howard mentioned nutrition programs as they have been carried out in Bridgeport where they were met with great enthusiasm.

Dr. Gilman extended the greetings of the Advisory Committee and expressed the hope that his committee will soon meet with the Auxiliary board of directors on the question of programs for next year.

Mrs. Lambert then introduced Mrs. David S. Thomas who congratulated her on her splendid report rendered to the National Auxiliary. Mrs. Thomas emphasized that this organization has been formed for a definite purpose and is not a "playground," and that the members are one step ahead of the social worker. Doctors' wives must work together for the salvation of the profession, and support its high principles. Auxiliary members must bring understanding between Auxiliary and public. "We either progress or retrogress" stated Mrs. Thomas. There are so many problems today, we must build good team work with advice and guidance of the advisory committee. Mrs. Thomas also stressed the importance of public relations and increase of circulation of *Hygea* in schools. She suggested two projects for consideration for this year: juvenile delinquency and national fitness program. Both are of extreme importance at this time.

Reports of officers followed: Mrs. Creighton Barker, vice-president and organization chairman, reported that seven counties are completely organized, Tolland county expecting to do so in the fall. Secretary's report was read and approved. The report of the treasurer was as follows: dues collected $563, expenses: clerical supplies $51.88, tea (semi-annual meeting) $30, Christmas letter $24, dues refunded $4—$109.88, balance on hand $453.12. Since reports of standing committees were published in the JOURNAL a motion to accept them as published was asked by the president. Motion was made seconded and carried.

Reports of county presidents were given as follows: Mrs. James Douglas Gold, Fairfield county; Mrs. Arthur B. Landry, Hartford county; Mrs. Walter N. Nelson, Middlesex county; Mrs. Luther K. Musselman, New Haven county; Mrs. Alfred Labensky, New London county and Mrs. Ralph L. Gilman, Windham county.

Mrs. Lambert then spoke on the first year of the Woman's Auxiliary and plans for the future.

After the president's address Mrs. Frederick W. Wersebe, chairman of the nominating committee brought in a slate of officers for election prepared by her committee as follows: President, Mrs. James Raglan Miller; President-elect, Mrs. James Douglas Gold; First Vice-President, Mrs. Creighton Barker; Second Vice-President, Mrs. H. Bertram Lambert; Recording Secretary, Mrs. Charles W. Goff; Corresponding Secretary, Mrs. Edwin R. Connors; Treasurer, Mrs. Julian G. Ely.

After the slate was read the president asked for nominations from the floor; there being none a motion was made from the floor to accept the slate as presented and to have the secretary cast one ballot. This motion was seconded and carried and the officers were duly elected. Mrs. James Raglan Miller briefly addressed the meeting. Mrs. Benjamin P. Burpee spoke on Auxiliary work in other States throughout the country.

Following her address the meeting was adjourned and tea was served by the committee on arrangements, Mrs. Herbert Thoms, chairman.

Mrs. Charles W. Goff, Secretary

## Litchfield County Organizes

Litchfield County Woman's Auxiliary held their organizational meeting on May 18 at the Nurses' Home of the Charlotte Hungerford Hospital in Torrington. Mrs. Donald Herman of Winsted, temporary chairman, conducted the meeting. The following officers were elected: President, Mrs. W. B. Walker, Cornwall; Vice-President, Mrs. Thomas J. Danaher, Torrington; Secretary, Mrs. J. F. Kilgus, Litchfield; Treasurer, Mrs. Arthur H. Jackson, Washington.

A social hour with tea served followed the business meeting.

## New London County Annual Meeting

The annual meeting of the New London County Woman's Auxiliary was held on May 16 at the Norwich Inn. Following luncheon, reports were read and Mrs. Harold Wellington, chairman of committee on legislation read the constitution and by-laws, which her committee had prepared. These were accepted by the membership. Mrs. Labensky announced the following standing committee chairmen: Legislation, Mrs. Harold Wellington, New London; Membership, Mrs. Thomas Murray, New London; Program, Mrs. Clarence Thompson, Norwich; Public Relation, Mrs. Willard Morse, New London; *Hygea*, Mrs. Lawrence Ward, Niantic; War Participation, Mrs. Julian G. Ely, Lyme.

Mrs. Edith Valet Cook spoke on social legislation in general with particular emphasis on the Murray-Wagner-Dingle bill.

## Fairfield County Annual Meeting

The annual meeting of the Fairfield County Woman's Auxiliary was held on May 17 at Stratfield Hotel, Bridgeport. Dr. James Raglan Miller, chairman of the Council of the State Medical Society and president of the New England Surgical Society, spoke on "How Far Is It Safe To Socialize Medical Care?" After Dr. Miller's address, Mrs. Gold, president, introduced Mrs. H. Bertram Lambert, president of the Woman's Auxiliary to the Connecticut State Medical Society, and Mrs. Creighton Barker, vice-president, who extended greetings to the members. Reports were read and Mrs. George Buckout presented the constitution and by-laws to the members. These were approved and accepted.

## Nassau County (N. Y.) Auxiliary Contributes

The Nassau County (N. Y.) Auxiliary contributes each year to Physicians' Home, Inc., a project of the State Auxiliary. Through this organization indigent physicians and their wives of New York State are given help. To raise funds for this project Nassau County Auxiliary recently held a dessert bridge.

## What the Auxiliary Can Do

The Woman's Auxiliary to the Medical Society of Milwaukee County, Milwaukee, Wisconsin, presented a health program recently at the Milwaukee auditorium which might serve as a pattern for other auxiliaries. Speakers included Dr. W. W. Bauer and Dr. Austin E. Smith of the American Medical Association headquarters' staff, Dr. Clifford J. Barborka of the Northwestern University Medical School and Dr. E. R. Krumbiegel, Milwaukee Commissioner of Health. The moderator was Dr. J. J. Moore of Chicago, treasurer of the American Medical Association. In spite of bad weather five hundred women were present for the morning session and a greater number in the afternoon.

Exhibits were a feature of the meeting, presented by the American Medical Association, under the direction of Dr. Thomas G. Hull, Marquette University Medical School and a large number of other local groups. Many hundreds of school children were present, with their teachers, crowding the facilities of the auditorium.

Milwaukee is to be congratulated on the program which was initiated so successfully this year, and on a group of women who could do such a good job. The preliminary publicity was excellent. Already plans have been made for a two day session next year. For details write Mrs. Edward J. Bartes, president of the Milwaukee County Auxiliary.

# ANNUAL REPORTS

*(Concluded)*

## OF THE CONNECTICUT STATE MEDICAL SOCIETY

1944 - 1945

## SUPPLEMENT TO SECRETARY'S ANNUAL REPORT

May 23, 1945

CREIGHTON BARKER, M.D.

*At the time the Secretary's Annual Report, which was published in the June* JOURNAL, *was prepared the war in Europe had not ended and a report of the termination of the Emergency Medical Service in Connecticut would have been premature. After the conclusion of European hostilities and the announcement of plans for ending most of the State War Council activities this supplementary report became timely and it was presented as a part of the Secretary's Report for the House of Delegates on May 23.*

The Secretary's report would be manifestly incomplete if reference was not made to the course and termination of the Society's extraordinary war activities. The record of these years is filed in the archives of the State of Connecticut and the United States and I will review it but briefly.

In June 1940, a year and a half before this nation entered the war, the House of Delegates of the American Medical Association urged each state society to establish a Committee on Medical Preparedness. Soon thereafter Dr. Landry, then President of the Society, Dr. Miller, the Chairman of the Council, and myself acting as the Executive Committee of the Council during the summer months, asked Dr. George M. Smith to accept the Chairmanship of that Committee. At that time none of us knew what an undertaking it would be in the five years that were to follow, but Dr. Smith accepted the appointment, and all will agree that this choice was a wise one.

The first actual responsibility the Committee faced was a request from Governor Baldwin and the State Selective Service that the Society accept the responsibility for organizing the medical examining and advisory boards within the Selective Service. This was done promptly and somewhat later at the request of the First Service Command of the Army the Hartford Induction Center was established under the supervision of Donald B. Wells. Since those days, hundreds of members of this Society have participated in the operation of the Selective Service and under the official direction of Lt. Col. William B. Smith, Chief Medical Officer of the Selective Service in Connecticut, a medical system has continued at the highest peak of efficiency and has received the compliments of National Selective Service. Later on the Armed Forces Induction Center was removed to New Haven and established there under the civilian direction of Dr. Bliss Dayton and in command of Major Charles C. Verstandig. All of these activities have been coordinated by Dr. Smith's Committee.

In the autumn of 1940, when the state itself saw the necessity for forming a War Council, a memorandum relative to medical participation and the functions of the medical service was prepared by Dr. Smith and submitted to the Governor. That memorandum still stands as a wise appraisal of the responsibilities that the civilian medical profession should assume in war time. Dr. Smith became the medical member of the State War Council and has continued as one of the most active members of the Council until this day.

The extent of the exactions that would arise in developing the civilian medical program could not be anticipated. There came the necessity for establishing the Emergency Medical Services that were developed under Dr. Smith's direction by Dr. Ralph E. McDonnell who separated himself from private practice to accept a commission in the United States Public Health Service Reserve to act as the Deputy Chief of the Emergency Medical Service in the state.

Hospital planning and mobilization was carried out by Mr. William B. Sweeney of the Windham Community Hospital, Willimantic.

Later the Office of Civilian Defense authorized the organization of seven base hospitals in Connecticut under the Public Health Service and this part of the program was carried out with a high degree of patriotism and efficiency with scores of skillful physicians and surgeons commissioned as reserve officers in the United States Public Health Service to man these hospitals if need arose.

No one who has not been in intimate contact with all the phases of this wartime program could possibly understand the myriad of details that have been carried out under Dr. Smith's administration. It included an independent and complex communications system, plans and equipment for emergency hospitals, an independent transportation system, and widespread arrangements for the evacuation of civilian population to zones of safety. Some of it seemed fantastic, but none the less it had to be done and had disaster come upon us without this preparation, an untold number of lives would have been lost. By great good fortune, it was never necessary to mobilize these forces, but they were ready, equipped, and trained, and the people here, although they did not know of the vast establishment that had been created for their protection, unconsciously had a feeling of confidence.

With the cessation of hostilities in Europe and the removal of the threat to this part of our homeland, the necessity for this great organization has practically been removed. The State War Council is about to dissolve and end most of its functions and the next few months will see the virtual disbanding of this system that was developed for the protection of the community. The whole will remain in history as an everlasting credit to the physicians of Connecticut guided and led by Dr. Smith.

## REPORT OF THE PRESIDENT

At this time, according to a long established custom, your president is expected to report on the "State of the Nation." The "State of the Nation" in this particular instance refers to the Connecticut State Medical Society.

During the past two years that it has been my privilege to serve as your president-elect and president, many momentous events have taken place in this state. this country and this world. I will simply touch on a few of the many important questions which have arisen during the past year concerning the affairs of the Society.

I have visited all the County meetings at their annual and semi-annual conclaves except one. I did not attend this meeting because I did not know about it until too late to make the necessary arrangements. It would be an excellent idea if all County Associations would send notices of their meetings directly to all the officers of the State Society. I feel it is an excellent idea for the executive secretary, the chairman of the Council and the president, as far as possible, to attend the County meetings, because in this way they can bring to the separate Counties what the State Society as a whole is doing and thinking about and, in return, they can find out what the separate Counties are doing, thinking and worrying about.

I feel it would be an excellent idea, when the clouds of war have drifted away and the sun of peace again shines on this land, for the president of the State Medical Society to have as his guests the president and/or the secretary of the component County Associations two or three times a year, wine and dine them and find out what is on their minds. This might be a legitimate expense for the State Society to assume.

At one of the County dinners the president asked me how we could improve the State Society. My reply to him was as follows—and I still feel it was a good answer—"A chain is no stronger than any one link." Thus, the important thing to be accomplished is for each individual link, the County, to strengthen itself, then the whole chain, the State Society, will be welded into a stronger and more efficient chain.

In pursuance of a request from the O.D.T. the annual meeting was cancelled. I am sorry that such a decision was necessary, because the local committee at Hartford had set up an elaborate and interesting plan for the entertainment of the State Society. Also the program committee had prepared an excellent scientific program and the various essayists had sent in their acceptances.

During the last year the Procurement and Assignment Service has had very little to do, as most of the work had been done previously to that date.

There has been set up at the office of the secretary of the Society a mechanism whereby returning medical officers may receive help, aid and assistance in re-establishing themselves in civilian practice. This will be a great boon to returning doctors and I am sure the work will be well done, because the chairman of this project will be the same man who is chairman of the Procurement and Assignment Service. I would, at this time, like to express my own deepest appreciation and sincere thanks as well as that of the members of the Connecticut State Medical Society and of the people of the State of Connecticut to the Procurement and Assignment Service of this State for its painstaking work and judicial decisions which it has had to make on various problems in order to obtain such an excellent result whereby the proper quota of medical officers was inducted into the armed forces and at the same time sufficient civilian doctors retained at home to adequately administer to the needs of the State of Connecticut during these trying war years.

The Woman's Auxiliary is now a going concern and a truly great addition and help to the State Society. The various County Auxiliary groups have independently organized and are progressing nicely.

Two years ago in this very city, in my acceptance speech, I stated that I was very much interested in a permanent location for the home office of the Connecticut State Society, and I still am. I feel the trustees of the Building Fund have done, are doing and will continue to do an excellent job on this project. The sum of money which they have set themselves to obtain is growing in a healthy manner. I trust that they will keep clearly in mind that procuring a little more working space for the executive secretary's office is not the main object of the project. The first step might be to procure a house, which is already built and so located that it would take care of the needs on a more or less temporary basis. This building would also serve as a "mock-up." In this way we, and the people coming after us, could better determine what purpose it was to serve, where it was to be located, and who the tenants might be. After these problems have been more or less satisfactorily settled, construct a building in a place where the surroundings might be pleasant and agreeable and where there would be room to expand in the future if necessary. This building might contain the state office of the Connecticut Hospital Association, the Connecticut Pharmaceutical Association, the Medical Examining Board, as well as the home office of the Connecticut State Medical Society and such other organizations as might be associated with the care of the sick in the State of Connecticut. In such a set up, many of the activities which have to do with the health of the State of Connecticut would be housed together, they would get to know each other, and I am sure in the end it would work out to the best interests of every one concerned.

The Connecticut Hospital Service, Inc., or, as it was known in its beginning, the Connecticut Hospital Plan, Inc., has been running about eight years and as I have been intimately associated with this corporation, it is a great satisfaction to see the healthy growth during this period. This Corporation has to do with the part payment of the hospital bills of the patients.

The next thing to do was to make some sort of an arrangement so that part or all of the doctors' fees would be taken care of. For a long time we have been toying with the idea of pre-payment medical care. The Enabling Act which permitted formation of this pre-payment service was set up at the last legislature. Under House Bill #999, An Act Empowering the Connecticut Hospital Service, Inc. to contract with and Act as Agent for Medical Service Corporations, was passed by the Senate on May 15 and by the House on May 8, 1945.

The Connecticut Medical Service, Inc., is to have a Board of Directors consisting of eleven members, appointed as follows:—six selected from the Connecticut State Medical Society and five from the public at large. Thus, the majority of the Board members will be members of the Connecticut State Medical Society, where the control of this corporation surely belongs. Its activities should be separate from the activities of the office of the executive secretary. It will not be long, if the corporation progresses, before it will be very evident to the Board of Directors that they must procure some one to run it who wants to do it, in fact, might make it his life work, who is competent and who shall receive a living wage. At first we should go slowly in this matter and insure only those of a catastrophic nature, such as surgery and obstetrics.

During my connection with the Council, extending over a period of about six years, it has been a very interesting type of work and I have enjoyed very much the congenial atmosphere that prevails at their meetings. The Connecticut State Medical Society has invested in the hands of the Council practically the running of the affairs of the entire organization and I feel they must be deeply conscious of their duty and the responsibility that has been placed upon them. One of these duties is to nominate some committees and to elect others, and practically all nominations which they have presented have been passed on favorably by the House of Delegates. The Council, therefore, must be very careful in the selection of the men on the various committees, and I personally feel that the Council should be held responsible for what these committees do, or, what is more important, what they do not do. They should have a check on them and if things are not carried out, the Council should make every effort to find out why the work has not been done. During my association with the Council there have been several matters which the Council itself had to investigate and take care of, which should have been done by the committee in charge of these separate matters.

The members of this Society, because there will be no annual meeting, will not this year have to listen to a presidential address. I have prepared a skeleton of such a paper entitled "The Obligations of a large non-university Hospital, as the Hartford Hospital, to the community and the community's obligation to such a Hospital."

One of the points was that the hospital should always have in mind the importance of the elevation of the practice of medicine in the community where the hospital is located. The Connecticut State Medical Society had much to do with the formation of the Yale University School of Medicine, the Institute of Living, the State Board of Health, and other activities for improving the health of the people of this State. Because of the trying period which we are going through, perhaps the standards of medicine are unconsciously being lowered. I suggest at this time that the Connecticut State Medical Society appoint a committee whose sole function would be to study the problem of the elevation of the practice of medicine in this State. There are many angles to this problem, as the formation of a second medical school, postgraduate education in the various communities, and the "branch banking," an idea about which I have talked on various occasions and will not at this time again bore you.

It is impossible for me to bring this short report to a close without expressing my deep appreciation for the confidence which this Society has placed in me and by the way it has honored me by elevating me to the highest office it is within its power to give, and if, at any time in the future, this Society feels that I might be able to contribute to its welfare or to that of the community, I wish they would feel free to call upon me. As I step aside and turn this office over to other hands, I would like to say as I did on another occasion, quoting the blind poet, Milton, "They also serve who only stand and wait."

H. Gildersleeve Jarvis

## REPORT OF THE COUNCILLOR OF HARTFORD COUNTY MEDICAL ASSOCIATION

The activities of the Hartford County Medical Association will be amply covered at this meeting, I am sure, by the Chairman of the Board of Directors, the Secretary and the various committees of the Association. Then, too, the activities of the Council of the State Medical Society in the past year have been reported monthly in the State Journal by the Secretary of the Society. I shall, therefore, limit my report to such matters as, in my opinion, should be emphasized and others which may well bear repetition without unduly trying your indulgence.

But first permit me briefly to refer to two items contained in the Councillor's report at the last Annual Meeting. You will recall that I alluded to the criticism, on the part of some of our members, that insufficient information on the deliberations of our State Council was imparted to the membership of the Society and that something should be done about it.

This was brought to the attention of the Council and there immediately followed the monthly publication of more detailed minutes of the Council meetings, in the State Journal.

The second item concerned the lack of representation of certain towns on important committees. This criticism bore fruit—and particular attenton has been given to wider distribution of committee appointments.

At the last Annual Session of the State Medical Society, held in Bridgeport, Governor Raymond Baldwin suggested that a Medical School be established at the University of Connecticut. This forward-looking suggestion, contemplating a part of the natural expansion of the University, evoked favorable editorial comment in some of the newspapers of the State but raised only scant enthusiasm in our medical ranks. To be sure, the time for initiating such a project seemed to some inopportune; but it was certainly in line with post war planning and revealed, I think, an expression of the people of the State, as well as a hint to the medical profession of what is to be expected of a young and robust university striving to meet the educational needs of the State.

Shortly after the Governor made his suggestion, Hartford County members of the Council met to discuss it and the consensus of this group was that interested hospital staff members in this vicinity should be brought together to sound out their feelings in the matter. This meeting was held in this building, but so far as I know, nothing tangible ever came out of it.

It may be worthwhile to observe here that the Governor's suggestion should have very careful consideration of this County Association. Surely the question of establishing a medical school at the University is one which compels discussion and should have the attention of organized medicine, particularly in this County, which, because of its hospital facilities and their proximity to the University would in all probability have to play an important role in any medical school project at the University.

May I respectfully recommend that the Hartford County Medical Association take a leading part in exploring the possibilities of such an undertaking. It is not too early, it seems to me, to appoint a committee to study the advisability of establishing a medical school at the University of Connecticut.

A few years ago Dr. Creighton Barker, Secretary of the Connecticut State Medical Society, in his report to the House of Delegates suggested a home for the Connecticut State Medical Society, after carefully noting the many reasons therefore. The suggestion was acclaimed an excellent one and his report was published in the Journal. Subsequently, the House of Delegates authorized the Council to organize the Trustees of the Building Fund of the Connecticut State Medical Society. This authorization was also published in the Journal. The Trustees were not long in starting their work and in due course of time sent to the membership a pamphlet again explaining the purpose of the Building Fund and soliciting contributions from all members, except those in the Military Servce. Their project received editorial attention in the Journal, yet I have been informed by some members that they knew nothing of the building project and wondered why they should suddenly be called upon for contributions. All of which is to the point that the contemplated home for the Society has been well publicized and that a few members through lack of knowledge and adverse criticism might dampen the efforts of the Trustees.

In the March issue of the Journal there is a splendid message entitled: "A Vested Interest in your Society," by President H. Gildesleeve Jarvis, in which he eloquently appeals for our support of the Building Fund. If you have not already done so, please read his message. I am sure you will find it stimulating.

At the special meeting of the House of Delegates held December 7, 1944, an amendment to the State Society By-Laws was passed authorizing membership in the State Society for Medical Students and making any student member "eligible at once for election to active membership in the County Association in the County in which he has settled, without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Association." Presumably a student member may retain his membership status in the State Medical Society until he is elected to the County Association or while awaiting the completion of the period of residence which, according to our By-Laws, is one year. It would seem wise to amend our County Association By-Laws, to waive the period of residence for all student members of the State Medical Society who located in Hartford County.

In line with the establishment of student membership in the State Medical Society, the Board of Directors of the Hartford County Medical Association has carefully considered the desirability of having student membership in our County Association. At one of their recent meetings the Directors voted to present for your consideration changes and additions to our By-Laws authorizing such membership. The proposed amendments will be presented to you shortly.

Upon the request of the State Director of the Office of Price Administration for Connecticut for "the State Society to appoint Boards of Medical Advisors for district rationing boards to pass upon the validity of requests for extra food rations submitted by physicians," the State Council complied and appointed members to serve in their respective counties. Because of unavoidable delay in getting organized,

the Hartford County board did not function as a unit but appointed members acted independently on physicians' requests for additional ration points for patients. This was, of course, unfortunate and created misunderstanding all around. However, all this has been corrected and now there are two advisory boards serving this County.

The many health bills pending in State and National legislatures deeply concern our physicians lest their clinical freedom be restricted. According to current reports, the famous Murray-Wagner-Dingle bill, to mention but one, will soon be reported out of committee in a somewhat modified form. Our Committee on Public Policy and Legislation will have much to do in keeping up with the grist as it comes from the mill, and, no doubt, individual members of the Association will have to keep in touch with their representatives to see that their freedom of practice is not abrogated.

Respectfully submitted,
Arthur B. Landry

# CORRESPONDENCE

Somewhere in China
May 8, 1945

To the Editor:

Thank you for your letter of January 31 which arrived a week or so ago. Actually, I have been thinking of writing you for some time to let you know that the CONNECTICUT STATE MEDICAL JOURNAL has been following me faithfully for about a year. It has been sent to the address you listed, and from there forwarded to me here. I have enjoyed receiving it very much.

I have been intensely interested in the Society's activities as recorded in the JOURNAL, and have become increasingly attached to Connecticut the longer I have been away from it.

My work here includes training doctors for the Chinese Army Medical Corps. In November we sent away one class, and have another in training now.

Thank you again for your interest and for sending the JOURNAL so regularly.

Paul J. Laube, M.D.

## United States Senate
## Washington, D. C.

May 31, 1945

To the Editor:

On Thursday, May 24, I introduced with Senator Murray a bill, S. 1050, entitled: "The Social Security Amendments of 1945." The bill provides for "the national security, health and public welfare." Representative Dingell of Michigan introduced a companion bill (H. R. 3293) in the House at the same time.

I am forwarding the bill itself, and a copy of my speech in the Senate for your information and use.

I particularly invite your earnest study of the provisions of the bill relating to health. There is absolutely no intention on the part of the authors to "socialize" medicine, nor does the bill do so. We are opposed to socialized medicine or to State medicine. The health insurance provisions of the bill are intended simply to provide a method of paying medical costs in advance and in small convenient amounts.

During the formulation of this bill, we have benefited greatly from the constructive advice and suggestions of practicing physicians, and of physicians in clinical and teaching positions. Their constructive suggestions have resulted in changes in the bill which we presented in the last Congress. Undoubtedly other changes will be made before this bill is enacted into law. We wish to have it known that we invite constructive suggestions from the medical profession.

In addition, members of the medical profession will be given full opportunity to voice their opinions in open hearings when the bill is considered in Committee.

I hope that you will print this letter in your JOURNAL and that you will join me in urging the medical profession to undertake an earnest study of the actual provisions of the bill. In this way you can help immeasurably in avoiding misunderstanding and misinterpretation of the legislation and in stimulating physicians and medical and hospital organizations to come forward with constructive suggestions and advice.

Sincerely yours,
Robert F. Wagner

## Office of The Medical Information Bureau
### OF THE HARTFORD MEDICAL SOCIETY AND HARTFORD COUNTY MEDICAL ASSOCIATION

April 2, 1945

C. J. McCormack, M.D., Secretary
Hartford County Medical Association,

Gentlemen:

Your representatives on the Medical Information Bureau have felt that there is considerable medical misinformation finding its way into the public press.

Furthermore they feel that we have a social responsibility to offset that misinformation with sound scientific medical facts. They further realize that on numerous occasions many of you are called upon to address groups of various kinds either by formal medical papers or less formally on the public forum.

For these reasons they feel that any member who makes a public or professional address in the field of medicine would render the community and the profession a distinct and invaluable service if the content of such talks could be sent to the Medical Information Bureau in advance so that the necessary accurate press releases could be prepared and furnished the newspapers.

Only in this way can medical accuracy and adequate news coverage be consummated in the interest of good public relations.

Very truly yours,
The Medical Information Bureau,
Alfred L. Burgdorf, M.D., *Chairman*

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## The Blue Cross Controversy in Pennsylvania and Wisconsin

For years the American College of Radiology has warned that if a few medical specialties were surrendered to hospital and Blue Cross domination, a basic principle would be sacrificed and complete domination of all of medicine would eventually follow. Too often these admonitions have fallen on unheeding ears.

The infiltration process having been partially acomplished, there are unmistakable indications that a frontal attack upon the main body of American medicine is under way. Blue Cross plans in several sections of the country are boldly moving to take over complete control of prepaid medical and surgical service.

Philadelphia Blue Cross proposed a bill in the Pennsylvania legislature authorizing it to contract with doctors and furnish medical care to subscribers. The state medical society, which operates its own surgical plan under an enabling act that requires a majority of doctors on the board of directors, opposed it. The bill was defeated.

Although the Blue Cross bill called for a "medical board," composed of doctors with full control over all medical features of the plan, the state society objected on the grounds that a separate medical service corporation under existing legislation was preferable. Blue Cross should be content to act as sales and administrative agent for the Medical Service Association of Pennsylvania, they argue.

The Board of Directors of the Philadelphia County Medical Society, which approved the Blue Cross bill, was soundly spanked by the county society, which reversed the action in a recent open meeting. And the Board of Trustees of the state society has repudiated the action of its Council on Medical Service which also approved the Blue Cross proposal.

Pennsylvania radiologists, who fought a bitter and unsuccessful battle back in 1937 to exclude radiology from Blue Cross benefits, will find familiar language in the statement of the chairman of the state society's Board of Trustees that "The Philadelphia Blue Cross plan appears innocent enough on the surface but behind the scenes it is being manipulated by individuals who have repeatedly shown a disinclination to cooperate with the doctors of this state."

A less than candid attitude by Blue Cross in fulfilling a promise made by its Board of Trustees concerning radiology rather eloquently justifies the medical society's mistrust. In demanding the inclusion of radiology among its benefits Blue Cross agreed to maintain a separate account and pay separate checks for these services which are described in its contract as "medical services incidental to hospitalization."

Eight years have passed during which Blue Cross has refused to fulfill its compromise agreement. Furthermore, its new bill would permanently assign radiology and pathology to the hospital. The proposed law provides that "Separate accounts with respect to receipts, disbursements, and reserves shall be maintained for hospitalization *including medical services ordinarily incident to hospitalization*, and for additional medical services respectively."

The chairman of the state society's Committee on Public Health Legislation declares that "The issue is clearly one of whether the Blue Cross is to be permitted, through enabling legislation, to seize corporate control of the private practice of medicine or whether doctors will be allowed to preserve their identity and independence under the centuries old code of free medicine."

An identical controversy is raging in Wisconsin, where, as in Pennsylvania, the daily newspapers are publishing mutual recriminations between Blue Cross and medical society spokesmen.

Officers of the Medical Society of Wisconsin, in

opposing a Blue Cross sponsored bill that would give the hospital controlled plan the right to contract for the sale of medical services, have objected to the inclusion of radiology and pathology among hospital benefits. "The issue here is whether medicine is to be practiced *in* a hospital or *by* a hospital," they declare.

In justifying the inclusion of radiology and pathology among hospital benefits, contrary to the Wisconsin enabling act which expressly forbids the inclusion of any medical services in hospital care plans, Blue Cross spokesmen are quoted as assuring the legislative committee that "these services are not medical services but part of the regular hospital services." Blue Cross added these medical services to its benefits over the unrelenting opposition of the Medical Society of Wisconsin several years ago.

The American College of Radiology believes that an increasing number of leaders of medical opinion are wondering if medicine may not succumb to the domination of lay controlled hospitals while the profession devotes its fullest attention to forestalling domination by government.

## The Role of the American Hospital

Despite shortages of nurses, laboratory technicians and doctors, American hospitals in 1944 gave four million more days of patient care than in 1943, Dr. Donald C. Smelzer, president of the American Hospital Association, recently told a nation wide radio audience when he was guest of honor on "Your America," the Mutual network program of the Union Pacific Railroad.

In his address, featured May 13 on "Your America" in observance of National Hospital Day, Dr. Smelzer announced that in order to meet increased public demand for hospital care, post war building projects are proposed which will add more than 180,000 hospital beds to the nation's total. He pointed out that this figure does not take into account plans for government hospitals.

Some of Dr. Smelzer's remarks follow:

"In 1944 the civilian hospitals of America gave four million more days of patient care than they did in 1943. At the same time, we have 60,000 doctors in the armed forces, as well as nurses, laboratory technicians and other hospital personnel who have left to serve the Army and Navy. Thus the increased public desire for good hospital care has exceeded our means of serving, and the hospital people remaining have been sorely pressed for time and energy.

"But this has not halted plans for the future. Our non federal hospitals are proposing post war building projects which will add more than 180,000 hospital beds to our nation's total. At the same time, the hospital of the immediate future will be further improved, with an emphasis on homelike conditions and colorful interiors, plus countless innovations for health, comfort and efficiency.

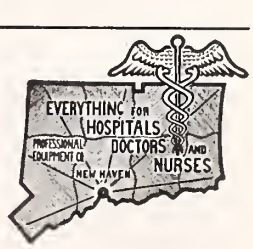
"Recognizing the importance of the community hospital in the health and welfare of the people, American hospitals are cooperating in developing and executing a common approach to our mutual goal—'Better Health for All.' The member institutions of the American Hospital Association appreciate the support and interest of the American people, who have made possible our voluntary hospital system. The aim of all hospitals is to be worthy of the confidence and faith of the people."

## Deaths Among Women Declined

The Metropolitan Life Insurance Company, in one of its recent bulletins, calls attention to the fact that the mortality among women in the main working ages of life has declined during the war period. This has occurred in the face of an increase in the past four years of 6,000,000 women workers who have replaecd men in civilian employment and of an enrollment of over 200,000 in the armed services. As the *Bulletin* points out, "although women were not set to do the most laborious and hazardous tasks in these industries, many of them were, nevertheless, subject to greater hazards than they had met in their ordinary pursuits in peacetime years."




BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# SPECIAL NOTICES

## NEW ITCH REMEDY

A new itch remedy, Circa 42, developed by scientists of the U. S. Department of Agriculture's Research Administration, relieves skin irritations caused by bites or stings of insects, such as chiggers, mosquitoes, spiders, wasps, and others, or by fungus infections, poison ivy, and "unknown" causes. Limited tests on persons in this country and in tropical areas have indicated Circa 24 to be a promising remedy for relief of itching skin for all but a few of those who have tried it.

Apparently, Circa 42 is not a universal remedy. A small percentage of persons do not respond and it does not relieve itching skin under all conditions. In recent tests of 32 persons who used this remedy for chigger bites, only two failed to obtain relief. For most of those who have tried it, relief from itching skin was obtained within 30 minutes. According to results reported so far, duration of relief from one application varies with individuals. Most of those who have used Circa 42 have had relief for 5 to 8 hours or more. For over a third of those tested, relief was permanent.

This remedy can be prepared by any druggist, who has the ingredients, from the formula developed by Dr. J. Franklin Yeager and Charles S. Wilson, entomologists at Agriculture's Research Center at Beltsville, Md. Circa 42 is a doughy non-greasy cakelike material, which is applied by hand in a thick layer over the itching regions, but not rubbed in. It is made of five materials, two of which produce a local skin anesthesia, without harm to the skin.

The formula for Circa 42 is as follows:

| | |
|---|---|
| n-butyl-p-aminobenzoate | 100 gm. |
| benzyl alcohol | 20 cc. |
| anhydrous lanolin (melted) | 20 cc. |
| cornstarch | 640 gm. |
| sodium lauryl sulfonate | 64 gm. |

More benzyl alcohol is added in mixing the other ingredients, according to the following directions provided by Yeager and Wilson.

1. Warm the benzyl alcohol, and dissolve in it the n-butyl-p-aminobenzoate making an approximately saturated solution.

2. Add melted lanolin, keeping the mixture warm and stirred until as much of the lanolin as will dissolve is in solution.

3. Mix well the cornstarch and sodium lauryl sulfonate, and add slowly to this powder, a little at a time, the warm liquid prepared in step 2. Knead this mixture to distribute the liquid evenly through the powder.

4. Add benzyl alcohol—about a tenth of that already used—to produce a doughy, non-greasy, cakelike ointment that can be packed in ointment jars or other suitable containers. It is better not to use containers made of metal.

## FALL REFRESHER COURSE IN LARYNGOLOGY, RHINOLOGY AND OTOLOGY

### At University of Illinois College of Medicine

The University of Illinois College of Medicine announces its sixth semi-annual Refresher Course in Laryngology, Rhinology and Otology, September 24 through September 29, 1945, at the College, in Chicago. The course is intensive and largely didactic, but some clinical instruction is also provided.

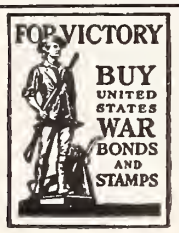
It is especially suited to specialists unable to devote a longer period for advanced instruction and to others seeking a comprehensive review of the field of otorhino-laryngology. The number of registrants will be limited. It is therefore desirable to apply for registration immediately. The fee is $50. When applying, give full details as to school and year of graduation, postgraduate training, college degrees, etc. Write to Dr. A. R. Hollender, Chairman, Refresher Course Committee, Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

## MEDICO-LEGAL CONFERENCE AND SEMINAR OCTOBER 1-6, 1945

### Boston, Massachusetts

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance during five of the six days of the course will be limited to fifteen persons who have registered in advance. On one day (October 3) the program will be open to any physician, lawyer, police official, or senior medical student who may care to attend.

Further information may be obtained from the secretary of the Massachusetts Medico-Legal Society, 25 Shattuck Street, Boston.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

## TUMOR CLINICS IN CONNECTICUT

### Sponsored by The Tumor Committee of the Connecticut State Medical Society

| CITY | CLINIC | CLINIC HOURS |
|---|---|---|
| Bridgeport | Bridgeport Hospital | 1st Friday each month 1:30 P. M. |
| | St. Vincent's Hospital | 2nd and 4th Thursday each month 12:00 N. |
| Danbury | Danbury Hospital | 2nd Tuesday each month 9:00 P. M. |
| Hartford | Hartford Hospital | Each Friday 10:00 A. M. |
| | Mt. Sinai Hospital | By appointment |
| | Municipal Hospital | Follow-up clinic 3rd Saturday A. M. each month |
| | St. Francis Hospital | Each Wednesday 11:00 A. M. |
| Meriden | Meriden Hospital | Each Wednesday 9:00 A. M. |
| Middletown | Middlesex Hospital | Last Wednesday each month 9:30 A. M. |
| New Britain | New Britain General Hospital | 1st Friday each month 10:30 A. M. |
| New Haven | Grace Hospital | East Tuesday 11:00 A. M. |
| | New Haven Hospital | Each Monday, Wednesday and Friday 10:00 A. M. |
| | | Each Monday 1:30 P. M. |
| New London | Lawrence and Memorial Associated Hospitals | 1st and 3rd Friday each month 9:30 A. M. |
| Norwalk | Norwalk General Hospital | Each Tuesday 11:00 A. M. |
| Norwich | William W. Backus Hospital | Each Wednesday 10:00 A. M. |
| Stamford | Stamford Hospital | Each Tuesday 10:00 A. M. |
| Torrington | Charlotte Hungerford Hospital | 1st Wednesday each month 11:00 A. M. Tumor Conference Only |
| Waterbury | St. Mary's Hospital | Each Thursday 11:30 A. M. |
| | Waterbury Hospital | Each Friday 11:00 A. M. |
| Willimantic | Windham Community Memorial Hospital | 1st and 3rd Monday each month 11:00 A. M. |

### TUMOR CLINIC SERVICE

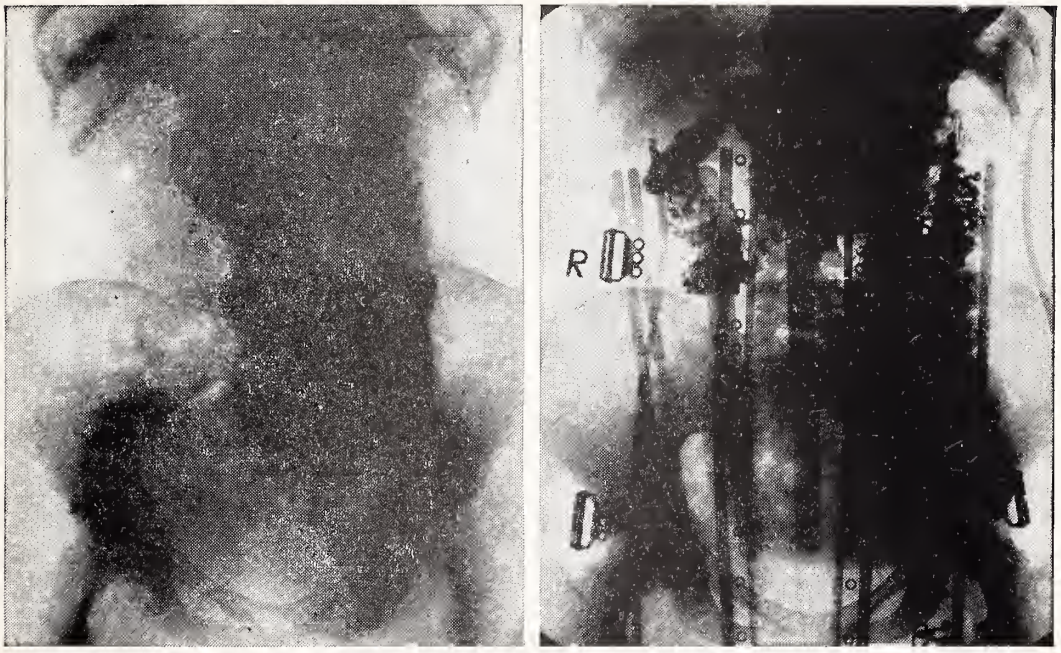
The Clinics listed here, attached to general hospitals, operate as diagnostic and follow-up clinics for patients referred with neoplastic diseases. Also held in conjunction with them are tumor conferences to which physicians are invited. Service is rendered free except in those instances where it is felt that the patient can afford to defray some of the cost. In such instances, a small charge is made.

These clinics constitute an important adjunct to the problem of cancer control in so far as they offer an opportunity for diagnosis and treatment to a class of patient financially unable to afford such service, and at the same time offer physicians the opportunity of obtaining group judgment in diagnosis.

## MENTAL HYGIENE CLINICS IN CONNECTICUT

| CITY | NAME | ADDRESS | HOURS | CLIENTELE |
|---|---|---|---|---|
| Bridgeport | Bridgeport Neuro-Psychiatric Clinic | 835 Washington Ave. | Fridays, 8:30 A. M. | Bridgeport adults and children with mental and nervous disorders |
| " | Bridgeport Society for Mental Hygiene | 1074 Iranistan Ave. | Mondays and Thursdays by appointment | Bridgeport adults and children with mental and nervous disorders |
| Bristol | Bristol Family Welfare Association | 451 North Main St. | Thursdays | Adults and children for psychiatric and mental hygiene service |
| Greenwich | Neuropsychiatric Clinic | Greenwich Hospital | Fridays, 1-4:30 P. M. By appointment only | Adults and children—local and out of town |
| Hartford | Hartley-Salmon Clinic | 79 Farmington Ave. Tel. 2-3179 | Daily by appointment | A child guidance clinic for metropolitan area with psychiatric consultation to social agencies on adult problems |
| " | Municipal Hospital Out-patient Clinic | 2 Holcomb St. | Each Wednesday, 9-12 A. M. | Neurological and psychiatric cases referred directly from Department of Public Welfare, also "follow-up cases" discharged from Municipal Hospital |
| " | Hartford Dispensary | 56 Winthrop St. | 9-12 A. M. | Clients from dispensary clinics and social agencies of Hartford |
| Mansfield Depot | Mansfield State Training School and Hospital Out-patient Clinic | Mansfield State Training School | Every Monday. By appointment | Children and adults from the district served by the Mansfield Training School |
| Middletown | Connecticut State Hospital Clinic | Connecticut State Hospital. Tel. 3700 | Saturdays or at other times by appointment | Any Connecticut citizen |
| " | Middletown Mental Clinic, District Nurse Association | 51 Broad St. Tel. 3490-3491 | 1st Wednesday in each month from 2-5 P. M. | Middlesex County residents |
| " | Middletown Child Guidance Clinic | 51 Broad St. Tel. 3490-3491 | Last Thursday in each month from 2-5 P. M. | Middlesex County residents |
| New Britain | Mental Hygiene Clinic of the New Britain Society for Mental Hygiene | 259 Main St. | Daily by appointment | Adults and children within the New Britain area. Also Consultation Service |
| New Canaan | Silver Hill Foundation | New Canaan. Tel. 9-1111 | By appointment every Thursday | Children and adults from neighboring districts |
| New Haven | Psychiatric Out-patient Clinic | New Haven Hospital. 789 Howard Ave. Tel. 5-1161, Ext. 750 | Full time by appointment | Adults and children. No special limitations |
| " | Mental Hygiene Service, University Department of Health | Dept. of Health, Yale University. Tel. 7-3131 | 8:30 A.M. to 5 P.M. daily | Yale University students only |
| " | Yale Clinic of Child Development | 14 Davenport Ave. Tel. 5-1161, Ext. 651 | By appointment | Infants and pre-school children with social, developmental and behavior problems |

***WHEN*** *digestive symptoms and general malaise are accompanied by marked downward displacement of the viscera, they are often relieved by* ANATOMICAL SUPPORT.




*X-Ray of patient with visceroptosis. (Left) The lesser curvature of the stomach is below the crests of the ilia. (Right) X-Ray of same patient after application of Camp Support for visceroptosis indicating how the viscera is held in a more nearly normal position.*

# Visceroptosis Support – CAMP

The roentgenologist may or may not find disturbed conditions in the duodenum... the displaced viscera being the only finding. For these patients, many physicians prescribe adequate rest, proper food at regular intervals, graduated exercises (especially for the patient with "visceroptotic habitus"), and a scientifically designed anatomical support. Numerous reports show that this treatment results in the gradual disappearance of the digestive symptoms with improvement in general health and weight gains for the thin patient. In time the support may be discarded.



*Camp supports for visceroptosis are fitted and adjusted with the patient in the partial Trendelenburg position. Pads are frequently used under the direction of the physician.*

Camp Supports are also of assistance for postural defects that so frequently accompany the visceroptotic condition.

S. H. CAMP & COMPANY • Jackson, Mich. • *World's Largest Manufacturers of Scientific Supports*

*Offices in* NEW YORK • CHICAGO • WINDSOR, ONTARIO • LONDON, ENGLAND

| CITY | NAME | ADDRESS | HOURS | CLIENTELE |
|---|---|---|---|---|
| New Haven | Psychiatric Service in the Community | 64 Trumbull St. Tel. 5-1161 | By appointment | Clients of the Social Service agencies of the New Haven Community Chest Area |
| Newtown | Psychiatric Out-patient Clinic | Fairfield State Hospital. Tel. Newtown 400 | By appointment | Children and adults from Fairfield State Hospital District, except communities served by local clinics |
| Norwich | Norwich State Hospital | Backus Hospital. Tel. 416 | Thursdays, 2-4 P. M. and by appointment | Patients from Norwich and vicinity |
| Stamford | Child Guidance Service | Family and Children's Center, 79 Worth St. | Monday - Friday, 9-5. Wednesday to 8 P. M. | Children with personality and behavior disorders |
| Waterbury | The Mental Hygiene Clinic of the Waterbury Society for Mental Hygiene, Inc. | 35 Field St. | Monday, Tuesday and Wednesday, 9-4:30 P. M., by appointment | Residents of Waterbury and vicinity. Consultation services to public and private agencies of Waterbury and vicinity |

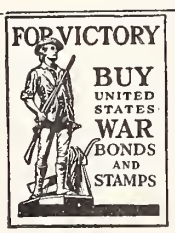
## CONNECTICUT STATE DEPARTMENT OF HEALTH

## BUREAU OF MENTAL HYGIENE

JAMES M. CUNNINGHAM, M.D., *Director*
1179 Main Street
Tel. 7-6341, Ext. 836

The Bureau of Mental Hygiene conducts psychiatric clinics for children, which meet once a week in the towns and places listed below. All referrals should be made directly to the above address and appointments will be given for the appropriate clinic

| CITY | PLACE | ADDRESS | HOURS | CLIENTELE |
|---|---|---|---|---|
| Hartford | Juvenile Court | 322 Washington St. | Wednesdays | Children referred by physicians, nurses, schools, public and private social agencies and others |
| Manchester | Manchester Memorial Hospital | | Mondays | |
| Meriden | Public Health and Visiting Nurses' Association | 69 East Main St. (2nd floor) | Thursdays | |
| New London | | 116 Huntington St. (2nd floor) | Mondays | |
| Norwich | | 9 Washington St. (2nd floor) | Fridays | |
| Torrington | Juvenile Court | City Hall | Thursdays | |
| Willimantic | Windham Community Memorial Hospital | | Wednesdays | |
| Winsted | Y. M. C. A. | | Thursdays | |




**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)

# OUR NEIGHBORS

## New York

Edward R. Cunniffee of Port Jervis has been elected president of the Medical Society of the State of New York for the year 1945-1946.

Dr. Augustus B. Wadsworth retired as director of the Division of Laboratories and Research of the New York State Department of Health after thirty-one years of continuous service. He developed this important function from very unfavorable and primitive conditions into one of the outstanding activities of the State, bringing to the work a well grounded background of clinical practice and teaching together with his previous accomplishments in fundamental research. This constituted a new standard for public health laboratories in a state, a fact which became widely recognized both here and abroad. From small beginnings the laboratory facilities in Albany grew until its staff numbered over four hundred persons and the annual cost well over a million dollars. This expansion of service to physicians is shown by the increase of diagnostic and sanitary examinations from about 20,000 in 1914 to over 1,190,000 in 1940. In addition, therapeutic and prophylactic preparations reached a total of over 660,000 packages. Many other services were furnished and a policy of decentralization with local autonomy was established, which constitutes a unique achievement in public health activities.

# NEWS
## *from County Associations*

## Fairfield

C. F. Yeager of Bridgeport is the author of "Industrial Medicine and the General Practitioner" published in *Industrial Medicine*, March 1945. In this article Dr. Yeager expresses the opinion that many more physicians will be required to assist industry in the post war period. He believes it will be necessary for American industry to depend mainly on the general practitioner to get this enormously important job done.

The regular monthly meeting of the Bridgeport


PRUNAMIN

- Two natural laxative ingredients (concentrated prune juice and pure mineral oil) blended into a mild, safe and effective aid to the correction of constipation.
- No harsh irritants . . . Just prunes and mineral oil, thus, PRUNAMIN can be recommended safely for young and old. No oily taste . . . only the flavor of rich Santa Clara prunes.




- PRUNAMIN was developed by Stoddard Brothers* at the suggestion of a group of physicians and now, after months of careful testing we submit this product for your consideration.
- We would be pleased to send samples upon request. Simply take one of your prescription blanks and mark on it, "PRUNAMIN PLEASE" and mail it to us today.

*Manufacturers of
Silver Birch Dry Prune Juice.
STODDARD BROTHERS, INC.,
501 Windsor St., Hartford 5, Conn.

Medical Society was held at the University Club on Tuesday, June 5, at 8:30 P. M. The speaker was Emerson L. Stone, assistant clinical professor of obstetrics and gynecology at the Yale University School of Medicine. Dr. Stone's subject was "Obstetrical Pediatrics."

## Hartford

Donald B. Wells is the author of "The Circus Disaster and the Hartford Hospital" published in the *New England Journal of Medicine*, May 24, 1945. Dr. Wells presented this paper before the annual meeting of the New England Surgical Society last September in Boston.

An appointment to an associate professorship in medicine at Tufts Medical School in Boston is the reason that John C. Leonard will leave the Hartford Hospital on July 1, having been assistant medical director and clinic director at Hartford Hospital since 1942. Dr. Leonard also will be in charge of the clinic at J. H. Pratt Diagnostic Hospital, and will be an associate of Bingham Foundation and Rockefeller Foundation for the extension of postgraduate medical education. His new office will be at Pratt Diagnostic Hospital, 30 Bennett Street, Boston. John T. Beebe, now assistant to Dr. Leonard, will take over the direction of the clinic here, and will be in charge of the intern teaching program in clinical medicine. Dr. Beebe, a graduate of Columbia University College of Physicians and Surgeons, interned at Hartford Hospital from 1940 to 1942.

## Tolland

Donald M. Beckwith has moved his office from Rockville to East Haven.

Capt. William Schneider, who formerly had an office in Rockville, has returned to the United States after almost three years of service in the South Pacific theater of war.

Walter C. Haviland, of Mansfield Depot, formerly physician-in-chief of the Mansfield State Hospital, died on May 13, 1945 after a protracted illness.

It has been announced that the new Rockville City Hospital will be opened as soon after July 1 as conditions permit.

## Windham

Putnam Hospital which started a Tumor Clinic in January 1945 has now been accredited by the State Association of Tumor Clinics.

# News from Yale University School of Medicine

William W. Peter, M.D., has resigned as associate professor of public health and chief of sanitary inspection in the Department of Health to become director of the training division of the Institute of Inter-American Affairs at Washington.

Lt. Comdr. Edward J. McCabe formerly of the Yale Department of Health and more recently a member of the V-12 Unit, at Yale University has been assigned to the U. S. Naval Hospital, Newport, Rhode Island.

# NEW BOOKS IN REVIEW

*DIETOTHERAPY: CLINICAL APPLICATION OF MODERN NUTRITION. Edited by Michael G. Wohl*, M.D., Associate Professor of Medicine, Temple University School of Medicine; Chairman, Advisory Committee on Nutrition, Philadelphia Department of Public Health. With a *Foreword by Russell M. Wilder*, M.D., PH.D., Professor of Medicine and chief of the Department of Medicine, Mayo Foundation; Member of the Committee on Medicine and Subcommittee on Medical Nutrition, Medical Sciences Division, National Research Council. *Philadelphia: W. B. Saunders Company.* 1945. 1029 pp. $10.

Reviewed by JOHN C. ROWLEY

As indicated by the title, this volume is not merely a book on dietetics nor is it a text book on nutrition in the usual meaning of that term. On the contrary, it is, first, a study of all the digestive processes and metabolism in the light of the latest physiological and biochemical research, and, secondly, it is the bearing and practical application of the current advances in nutrition upon those processes.

Since the last war, biochemists have made great advances in our knowledge of digestion and, particularly, of nutrition, but much of this information has been hidden in journals of biochemistry or physiology, not in easy reach of the general practitioner or specialist.

The authors, after sifting this mass of experimental data, have selected the significant facts and shown how they bear directly on preventive and every day practice of medicine.

A short chapter is devoted to the physiology and chemistry of each of the organs of digestion. Then in the light of this study the newer knowledge of nutrition is applied, largely through dietary measures. Other chapters are devoted to certain diseases, their effect on metabolism and the dietary measures necessary to counteract them.

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** Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
*Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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The common foods, minerals and vitamins are discussed separately in other chapters. The scope of the volume is evident by the following list of only a few of the chapter headings.

The normal diet—
The physiology of the gastrointestinal tract and its bearing on nutrition—
The role of protein in the diet—
Vitamin C in health and disease—
Dietary treatment of diabetes mellitus—
The relation of vitamins to oxidative enzymes—
The laboratory diagnosis of vitamin deficiency—
Nutrition in relation to infection and immunity—
Nutrition in relation to dentistry—
Nutrition in nephritis—
Nutrition and diseases of the skin—
Nutrition in the care of the surgical patient (preoperative and postoperative)

There are forty-four chapters, each written by a different author, an authority in his special field. At the end of each chapter, is an extensive bibliography. Another valuable feature is an appendix containing excellent tables and food charts, routine hospital diets, charts of foods as sources of the various vitamins, etc., all so arranged as to make reference quick and easy.

In spite of the fact that the volume is written by many authors, the material is well organized, clearly presented and remarkably free from repetition. Seldom does a volume throw so much new light on old subjects as does this one. The specialist, as well as the general practitioner. will find it interesting reading and a fine book of reference.

*PHYSICAL DIAGNOSIS.* (Third Edition, Revised.) *By Ralph H. Major,* M.D., Professor of Medicine, The University of Kansas, Kansas City, Kansas. *Philadelphia: W. B. Saunders Company.* 1945. 444 pp. $5.00

Reviewed by JOHN C. ROWLEY

With the ever increasing growth and importance of the laboratory and roentgenology in diagnosis, there is perhaps also a tendency to neglect the use of our five senses, particularly sight, touch and hearing, in examining our patients. These senses must be trained and constantly exercised. For this reason alone, this volume is of great value.

It guides the student in the best methods of making a physical examination and it contains 457 illustrations of the common and uncommon lesions that may be seen or felt—Von Recklinghausen's disease, obesity, gigantism, erythema nodosum and many others.

The chapters on palpation and auscultation are particularly outstanding. The material is well chosen and presented clearly and concisely. A brief history of the development of each of the different methods of examination, percussion and auscultation, the stethoscope, the thermometer, etc., stimulate the reader's interest.

More illustrations of the lesions of vitamin deficiencies might be included to advantage; otherwise, one finds little to criticize in this third edition of a book already greatly prized and deservedly so.

*DOCTORS AT WAR. Edited by Morris Fishbein,* M.D., Chairman of the Committee on Information of the Division of Medical Sciences of the National Research Council. *New York: E. P. Dutton & Co., Inc.* 1945. 418 pp. Illustrated. $5.00.

Reviewed by STANLEY B. WELD

Any tale of real accomplishment should produce a thrill within the reader, but when that tale discloses the sacrifices and achievements of those inside the family circle the thrill is magnified manyfold. *Doctors at War* contains not one tale but many, disclosing to the reader what huge strides medicine has taken since the attack at Pearl Harbor. The difficulties, the obstacles, the successes, and even some of the failures are all there. No story except this one has yet appeared recounting the work of the 186,000 physicians in the armed forces, in industry, and in civilian life during the war years of the present conflict.

Morris Fishbein, the editor, has done an excellent job in the first chapter, presenting an over-all account of how physicians mobilized their forces for war and the great achievements for which they have been responsible. Mortality figures of this war are compared with those of the last World War and the development of the new therapeutic agents is recounted briefly. To medical science in the United States goes the distinction of having attained a death rate for the man in service lower than that ever attained by any armed force in the history of warfare.

The other chapters deal in turn with Selective Service, Procurement and Assignment, development of the personnel of the Army Medical Corps, the work of the Army surgeon, of the Navy surgeon, of the Public Health physician, preparations for the invasion of Normandy, experiences at Guadalcanal and at Tarawa, the brilliant feats of the air surgeons, the program of convalescence and rehabilitation, the Veterans Administration, the wartime medical activities of the American Red Cross, particularly the blood donor service, and the work of the National Research Council—all are retold by the individual at the head of each phase of medical work or by an expert in that field. A few of the chapters will serve as references and are less interesting reading, others are packed with thrills and sustain the reader's interest to the last word. For example, Major General David N. W. Grant's story of the medical mission in the Army Air Forces is a dramatic account. All the gruesomeness of those struggles at Guadalcanal and Tarawa and the heroic achievements of officer and enlisted man may be found in Captain French R. Moore's account. Vice Admiral Ross T. McIntyre, Surgeon General of the Navy, makes one proud of the U. S. Navy Medical Corps to the last man, and the chapters by Surgeon General Kirk and Brigadier General Rankin, U. S. Army, leave little untold in the account of the Army medical officer's experiences. The chapter on the Veterans Administration should be of particular interest at this time.

It is true this book is for both layman and physician but every physician should read it. There would be a better understanding of the problems of Selective Service and Procurement and Assignment and a better realization of the sacrifices of one's fellow practitioners in this gigantic strug-

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gle. Through it all one may trace the results of American perseverance together with the astonishing results obtained from the development of four factors: air evacuation of the wounded, the use of plasma at the front, and the administration of the sulfonamides and of penicillin. The excellent illustrations add much to the attractiveness of this volume.

*THE NEW-BORN INFANT: A MANUAL OF OBSTETRICAL PEDIATRICS.* (Third edition, thoroughly revised.) *By Emerson L. Stone*, M.D., Associate Clinical Professor of Obstetrics and Gynecology, School of Medicine, Yale University; Attending Obstetrician and Gynecologist to the New Haven Hospital. *Philadelphia: Lea & Febiger.* 1945. 314 pp. $3.25.

Reviewed by STANLEY B. WELD

Although this third edition of Dr. Stone's book totals approximately the same number of pages as the second edition published seven years ago, because of narrower margins this present volume contains much more than its predecessor. Very little of the previous edition is omitted but much new material has been added. The major portion of this new material has been gleaned from contemporary writers on the various subjects during the past decade and opinions and findings are quoted extensively.

The pages on the treatment of syphilis with the sulphonamides and with penicillin are new. Also the discussion of vitamin K is brought up to date. In the second edition

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erythroblastosis fetalis received very cursory consideration; in this edition the five and one half pages devoted to it are quite complete and clearly expressed. The chapter on "The Premature Infant" contains much that reflects the sound judgment of the obstetrician and is quoted from an article by the author published in The Connecticut State Medical Journal, June, 1940.

This volume will continue to serve a useful purpose in bridging the gap in the newborn infant's life from the time of birth to the age of four to six weeks. It is not intended as a reference guide solely for the pediatrician, though many opinions expressed on such subjects as breast feeding might very well be carefully read by the pediatrician. The obstetrician will find much of value within its covers to guide him in those trying hours and days of the infant's life when a trained pediatrician is not always at hand. Dr. Stone is to be commended for his painstaking efforts in bringing this manual up to date.

*PRINCIPLES AND PRACTICE OF SURGERY. By W. Wayne Babcock*, M.D., F.A.C.S., Emeritus Professor of Surgery, Temple University; Acting Consultant, Philadelphia General Hospital; With the collaboration of thirty-seven members of the faculty of Temple University. *Philadelphia: Lea & Febiger.* 1331 pp., illustrated with 1141 engravings and 8 colored plates. 1944. $12.00

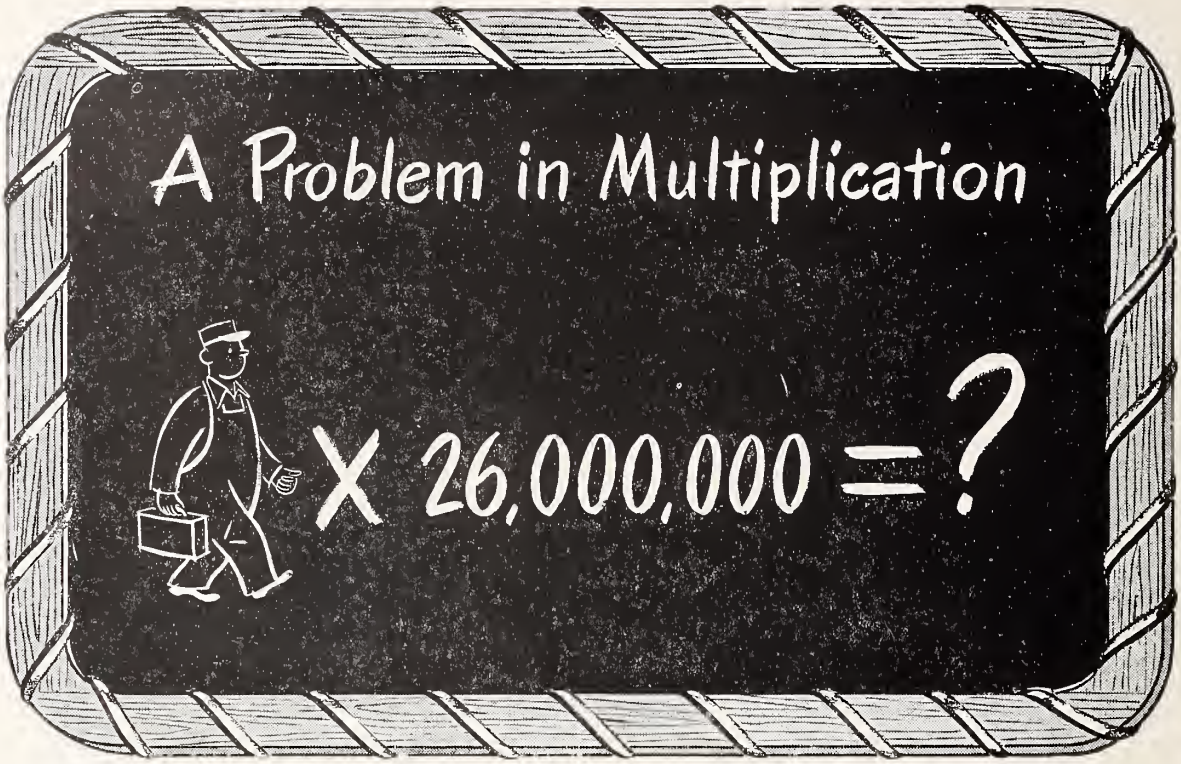
Reviewed by Edwin A. Lawrence

The author states in his preface that this book is intended to supply the student and the practitioner with a working knowledge of common and rare surgical conditions occurring throughout the world. The incorporation of much detail has been made possible by concise statement and careful editing. Particular attention has been devoted to the very recent advances in surgery. To avoid the weaknesses of both single and multiple authorships, thirty-seven collaborators were selected from the faculty of Temple University to apply their special knowledge, not to single chapters but to the entire book.

The four parts of the book are devoted to general surgery, surgical technic, the surgery of systems, and regional surgery. Emphasis on recent advances in surgery is exemplified by discussions of the use of the sulfonamides and penicillin, a detailed chapter on anesthesia in which both continuous spinal and continuous caudal anesthesia are discussed; and a description of recent intrathoracic operations, such as ligation of a patent ductus arteriosus and the direct esophageal operation for congenital atresia of the esophagus with tracheo-esophageal fistula.

Surgeons will disagree with certain sections of the book, such as that dealing with surgery of the stomach where too much space is devoted to a discussion of various types of gastrostomies and gastro-enterostomies at the expense of gastrectomy; and the section on large bowel surgery where the use of proctosigmoidectomy is emphasized. These criticism, however, do not detract from the value or importance of the book. It has a simple style, it is easy to read, and it contains an amazing amount of valuable information. It can be recommended for the student and practitioner as well as the general surgeon.




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VOL. IX AUGUST, 1945 No. 8

# THE HILL-BURTON HOSPITAL CONSTRUCTION ACT

At the first session of the 79th Congress a hospital construction act—S191 was introduced by Senator Hill of Alabama and Senator Burton of Ohio. This bill has been described as a "bill to amend the Public Health Service Act authorizing grants to the States for surveying their hospitals and public health centers, for planning construction of additional facilities and authorizing grants to assist in such construction." Hearings on the bill were started February 26, 1945 and it is from the record of these proceedings that the following excerpts from important and comprehensive statements are presented for the information of the members of our Society.

THE HONORABLE LESTER HILL IN DESCRIBING THE BILL SPOKE IN PART AS FOLLOWS:

"In the daily mail coming to my office there are always a number of letters requesting information or help on some matter concerning health, such as hospitalization, medical care, dental care, public health, and so forth. These letters are not from organizations or pressure groups, nor do they espouse any cause or any movement. They are merely appeals, and oftentimes pathetic appeals, from ordinary people with ordinary health problems which they have not been able to solve. By far the greatest number of these appeals are from communities which have no hospital facilities. Also a large number of letters tell me that no doctors are available. My medical friends say that these two situations are for all practical purposes one and the same thing, that where there is no hospital, there will be no well-trained doctors. They tell me, too, that this is not a temporary wartime condition, but that even after the doctors come back from the war they will not settle in communities where there is no hospital.

"After I had become aware that the lack of hospital and public health facilities and medical care constituted a serious threat to the health of the people in my own State of Alabama, I began to wonder if the same condition might not exist in other States too. Inquiry among several of my colleagues in both the Senate and House of Representatives confirmed my belief that throughout the entire Nation there was a serious need for a better distribution of hospitals, health centers, and medical services. I discussed this matter in particular with my friend, Senator Burton, and learned that even in the wealthy State of Ohio there existed many unmet health needs. Together we felt that here was a problem of great national significance which could be met only through the united effort of Federal and State Governments and the local communities.

"We then proceeded to acquaint ourselves more fully with the details of the health needs of the country. These details were supplied in abundance by numerous experts from all walks of life who came to testify before the Subcommittee on Wartime Health and Education of the Senate Committee on Education and Labor. This subcommittee, under the able chairmanship of Senator Claude Pepper, of Florida, assembled an enormous quantity of valuable information on the whole subject of national health. The testimony of the witnesses before this committee included the viewpoints of both those who render health services and those who receive them. It included the viewpoints of physicians, public health officers, hospital administrators, university professors, organized labor, business and farm groups. All this testimony added up to the inescapable conclusion that in the wealthiest country in the world, we have not yet organized our efforts to the end that scientific health care is readily available to all our people. We learned, among other things, that about 40 per cent of the counties of the United States have no recognized hospital facilities, that in these communities the normal pre-war ratio of

physicians to population was but a small fraction of that in other communities having hospitals. We learned that health centers or modern facilities for the practice of preventive medicine or public health are almost nonexistent and that at least 2,400 are needed now or as soon as personnel can be found to operate them. We and all the world learned the shocking fact that nearly 40 per cent of our young men of draft age were found to be physically unfit for military duty.

"From all these assembled facts grew the firm conviction that adequate hospital and public health facilities, properly distributed, were the first step in finding a solution to our national health problem. While not the complete answer in themselves, we were convinced nevertheless that no complete answer could ever be found until modern facilities are provided first.

"After arriving at the conclusion that Federal aid was necessary to any material improvement in our national hospital and health facilities, Senator Burton and I decided to introduce into the Senate a bill which would accomplish this purpose. In arriving at this decision we were fully aware of its far reaching significance. We determined therefore to proceed with caution and to avail ourselves of the best possible technical advice in preparing proposed legislation. For this advice we turned to the American Hospital Association, its affiliated groups, the Catholic and Protestant hospital associations, and to the American Public Health Association. We learned that these national organizations representing both hospitals and public health had individually and jointly arrived at the conclusion that a Federal-aid program to improve hospital and health facilities was the first step necessary to the improvement of our national health. With this solid professional backing both Senator Burton and I were encouraged to proceed with the preparation of legislation. We next set about to determine the type of Federal-aid program that would most effectively accomplish the desired results.

"In close cooperation with the professional organizations concerned we explored several possible methods of approach. Previous programs under which the Federal Government has aided civilian hospitals all seemed unsatisfactory for a long range, scientifically planned health program. All the professional organizations consulted were unanimous in insisting that certain broad general principles be made a part of any Federal-aid legislation. In brief these principles are as follows: First, that any hospital or other health facilities constructed with Federal aid be planned as part of a long range health development and not as incidental to a public works program; second, that no Federal funds should go into any health facilities until the need has been demonstrated by a careful survey; third, that construction shall be controlled through an agency of the State and not by direct Federal-local negotiation; fourth, that voluntary nonprofit hospitals as well as State, county, and municipal hospitals shall be eligible for assistance; fifth, that the principle of States' rights and local initiative be preserved and encouraged as essential to the success of any health program.

"In accordance with these principles and with the unanimous recommendation of the professional organizations concerned, it was decided that the United States Public Health Service was the agency of choice to administer a health-facility program. This decision was based upon the long and favorable record of the Public Health Service in administering other Federal grant-in-aid health programs and upon its wide knowledge of health and hospital problems.

"Accordingly, after due and careful consideration of all the factors mentioned before, Senator Burton and I introduced into the Senate as an amendment to the public health service law of 1944 a bill known as Senate bill 191, 'The Hospital Construction Act.' This bill authorizes Federal aid to the States on a variable-grant basis, for three purposes. The first purpose is to assist the States in making a careful Statewide survey of the hospitals and health facilities in the State in order to determine where additional facilities are needed and to prepare a Statewide program for new construction so that all people of the State may have adequate health and hospital service.

"Several States now have health and hospital surveys in progress or under consideration. Several of these are to be carried on by State Health departments. Very few States seem to have any specific appropriation enabling them to hire the necessary technical personnel to do a thorough job. The enactment of this legislation would augment these limited budgets and permit the types of survey necessary upon which to base a future construction program.

"The second purpose of our bill would be to assist States, counties, cities, and communities to provide for themselves modern hospitals and health centers as essential to the health of our Nation.

"The third purpose of our bill is to assist and encourage the States to correlate and integrate their hospital and public health services and to plan additional facilities when and where needed, in order to insure that in time all parts of the country will be adequately served.

"It is becoming increasingly clear to me that all parts of the country must have better health facilities and services. By the time this war is over, many of our men and women in the armed forces will have quite properly become accustomed to the best medical and hospital care known to modern science. Far better for the most part than they ever knew in private life. I cannot imagine that they will be willing to accept the catch-as-catch-can service they knew before in private life. They will demand and they will get the kind of health service they have learned to expect.

"It is my firm conviction, therefore, that the benefits provided in S191 are fundamental to the future health and welfare of the country. They are fundamental to whatever health progress we expect to make. No great increase in either public health, hospital, or medical services can be expected unless we have a much better distribution of modern hospital and health-center facilities."

DR. DONALD C. SMELZER, PRESIDENT, THE AMERICAN HOSPITAL ASSOCIATION MADE THE FOLLOWING STATEMENT IN PART:

"The American Hospital Association supports this legislation as it has supported other needed steps for improvement in our field. As an example, hospitals as an organized group developed hospital prepayment plans. These plans, working under the approval of the American Hospital Association and known as Blue Cross plans, now protect more than 16,500,000 of our population. This is decidedly the most practical and effective step in hospital care which has taken place in recent years and on a voluntary basis sponsored by public spirited citizens through their hospitals. The association's activity in this regard is indicative of our previous interest in the improvement in the distribution of hospital care.

"We support Senate bill 191 not only because it provides for assistance in the construction of hospital facilities but because we believe the proposed grants of Federal funds for that purpose will be the incentive for hospital and medical leaders and the general public to inventory present resources in each State and to develop as is required in this legislation an integrated program which will provide adequate hospital care for every citizen of each State.

"Every State under this bill will, through its survey and planning, be required to face squarely the present deficiencies in its hospital system and the distribution of medical service and plan those factors in that State which require attention if an ideal program is to be developed. I cannot too strongly recommend to you the value of such a study in our evolution of a better health system. It occurs to me that it is the way of which we make progress—the Federal Government furnishing the incentive, the technical skill and guidance, the State on its own initiative benefiting from such a system in proportion to the readiness of that State to adapt these aids to its own problems. The survey features of this bill will be extremely valuable as educational devices for the professional workers and for the public.

"In support of the general remarks which I have made I would like to emphasize certain aspects of Senate bill 191 which I believe are particularly important and advance the aims of this legislation.

"As with all Federal legislation, consideration must be given as to the division of authority between Federal and State Governments. Senate bill 191 seems to present a very sensible division in view of the need for local participation and understanding of the aims of the legislation and for some standardization of methods and supervision to insure the utilization of Federal funds in accordance with the purposes outlined in the bill. Hospital and medical care is a personal service. Many of the faults in our present system come through the lack of an integrated plan for the distribution of these personal services in such a fashion that they may be available to all of the people. On the other hand, such distribution to be successful must have the full support of the individual rendering the personal service.

"Support of those who must render service can best be secured by placing responsibility on local groups. This permits understanding by individuals concerned and makes possible plans which take into consideration the particular problems of various areas.

"The State seems the logical political subdivision. It is sufficiently large to permit the development of a plan which will utilize the professional and physical resources of urban areas to support adequate programs of care for rural areas. It is, of course, hoped that when this bill becomes a law, State funds will be used to supplement Federal assistance in

meeting the needs developed by the survey. There is, of course, also a need for funds for the operation of hospitals which is, at least in part, now assumed by the States. Support for the operation of hospitals might well be accomplished by the assumption of full responsibility for meeting the cost and care for indigent patients by the States and through Federal grants-in-aid.

"The most underprivileged groups of the population are those with subsistence at such a low level as to qualify them as socially and medically indigent. Hospital and medical care from their own funds for these groups and for certain of the less productive rural areas must come from support through public funds.

"The State survey which under the terms of this act insures participation by a State advisory council representing 'non-Government organizations or groups and of State agencies concerned with the operation, construction, or utilization of hospitals,' permits those concerned with the operation of hospitals and representatives of the public in each State to consult and advise with the State agency in inventorying present resources in each State and, of even more importance, in drafting a program which will integrate these resources with facilities to be constructed with Federal assistance to form an over-all program for care for all citizens of each State.

"Federal standardization is needed to assist States in preparing an over-all program. This is provided in Senate bill 191, the authority being centered in the United States Public Health Service, the logical Federal agency to advise on all professional matters in a proper plan for hospital care for the citizens of our country. The United States Public Health Service under this act will assist the States by serving as a clearing house for information developed in all States. With the benefit of experience in each of the States, the Surgeon General will, with the approval of the Federal Advisory Council, formulate minimum standards which a State must meet in order to secure Federal participation. This is the assurance that the State plan adequately meets the purpose as stated in this bill—

> to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar service to all of the people.

"Undoubtedly the survey in each State will determine a need for facilities far in excess of the amount authorized for appropriation under this bill during the first year. The bill provides that a State plan for meeting the purpose outlined in this bill must order the projects contemplated in the plan on the basis of need, Federal funds being allotted by the State administrative agencies in accordance with this ordering of need which must also be approved by the Surgeon General and Federal Advisory Council. There is then assurance under this bill that Federal construction will be on the basis of an over-all pattern and that any Federal appropriation will be devoted to the most pressing needs within each State.

"Without such Federal standardization there is no assurance that Federal money will be spent in accordance with the policies outlined in this bill. The proposed responsibilities of the Surgeon General are of necessity great. However, the bill very sensibly insures protection against arbitrary judgment by the Surgeon General and for participation by those experienced in administering health programs by creating a strong Federal Advisory Council.

"The Federal Advisory Council, which will be responsible for advising, particularly on technical matters, is to be a small council of eight members 'who are outstanding in fields pertaining to hospital and health activities, and a majority of them shall be authorities in matters relating to the operation of hospitals.' The State advisory councils, as provided under this bill, will be representatives of professional groups and of the general public, while the Federal Council, largely concerned with technical matters, will be primarily composed of persons with the experience needed to assist in these technical judgments. The abilities of the Federal Advisory Council will be an important factor in determining the success of this whole program. The bill states the qualifications of those appointed to this council.

"In order that such a program have the support of hospital boards of trustees, administrators, and the medical profession, it is important that those appointed be representative of these groups. The wording of the second sentence of section 633, page 14, beginning line 23, will, I am sure, be carefully considered by the committee. The wording might be strengthened were this sentence to read:

> "The eight appointed members shall be persons who are outstanding in and representative of fields pertaining to hospital, public health, and medical-care activities, and a majority of them shall be authorities in matters relating to the operation of hospitals.

"This bill will provide an opportunity to formulate a health program for the country based on adequate and detailed information as to the problem. There will be discussion and disagreement between various interests in the development of such over-all plans. The strong Federal Advisory Council will protect the Surgeon General from undue pressure and permit him to utilize this Advisory Council as support for objective judgment on the professional matters which will come to him for decision.

"This bill provides for the allotment of funds for construction to the States on the basis of three factors: (*a*) the population, (*b*) financial need of the respective States, and (*c*) in the case of allotments for construction of hospitals, the relative need for such construction. The allotment having been determined, the State matches Federal funds on a percentage basis, varying between 25 per cent by the poorest States and 75 per cent by the wealthiest State. The variation within the range of these percentages is determined for the several States on the basis of their relative financial need which we understand is a mathematically measurable factor.

"The hospital facility needs of certain of the States are such that in some States there might be argument for a direct Federal grant without State participation. However, we believe that the interest of local groups should be demonstrated, even in the poorest State, by a matching of at least 25 per cent. Health facilities to be of value to the population must have local support and interest. A 25 per cent financial participation with the Federal grant seems the minimum which should be required. On the other hand, the wealthier States are regularly investing substantial sums in hospital facilities and a participation of 75 per cent does not seem unreasonable. The Federal granting of 25 per cent to these States should be a marked incentive for even the wealthiest State to prepare an over-all program which will insure the necessary physical facilities for furnishing services to all the people. It is of interest to note that the bill provides that in evaluating the three factors in the basic allotment to States the final plan for allotment shall have the approval of the Federal Advisory Council and, if possible, the approval of the administrative officers of the State agencies. This follows the pattern developed by the United States Public Service Act insofar as approval of State agencies is concerned as it now operates with excellent results in grants of Federal funds for public health purposes to the States.

"This committee is undoubtedly familiar with the background of the nonprofit community hospital. Organized by the citizens of the community, these hospitals now render a major portion of the general hospital care to the citizens of this country. Many of these voluntary hospitals are operated by the various churches. Their organization and support results from the finest attitudes in our society. Private charity through these organizations endeavors to assist in the healing of all members of society. This bill provides that Federal funds may be granted to nonprofit hospitals and to hospitals owned and operated by subdivisions of Government. The voluntary hospitals of this country have played a dominant role in developing improvements in hospital methods and in raising the quality of hospital care for the people of this country. Public hospitals are needed, particularly for the care of mental patients and the tuberculous. However, it is fortunate that in legislation with the broad aims indicated in this bill, provision is made for maintaining the best in our present system of hospital service by making possible grants to both nonprofit and governmental hospitals.

"The bill by its definition makes eligible for grants not only general hospitals but mental and tuberculosis hospitals and health centers. All of these institutions are important in the formation of a State plan for necessary hospital service for all the people.

"This country has not yet fully formulated a proper pattern for the integration of health facilities. However, the health centers as provided in this bill are of particular importance. The rural areas of this country are, in many instances, the most underprivileged insofar as hospital care is concerned. There is no possibility of providing, closely adjacent to every rural resident, a hospital which will have all the diagnostic and treatment facilities needed for every disease. In these areas often the only hope for proper care is the health center having a limited number of beds for emergency care and for minor illness, such a unit also functioning as a center for the public-health activities in the community, a center for the health officer, and the public-health nurses. Depending on larger hospitals for the transfer of patients needing more complicated equipment and more highly skilled professional service, such health centers will also be dependent on these larger centers for assistance in professional supervision, particularly in diagnostic services such as roentgenology and pathology.

"While this bill makes no provision for maintenance of hospitals from Federal funds, we believe

that this omission is sound. To include such a provision so complicates the program that the initial steps which this bill aims to meet would be unduly delayed. Of first importance is the survey of need and development of facilities where adequate community support is fairly assured, followed by Government assistance for the medically indigent which will insure adequate community support.

"Blue Cross prepayment hospital insurance is doing much to insure adequate resources for the maintenance of hospitals. This prepayment program for hospital care is increasingly available and being utilized in rural areas. Many States already make provision for meeting the cost of hospital care for public indigent patients. The American Hospital Association believes that in addition to the provision of facilities as contemplated in this bill there should be Federal legislation providing grants-in-aid to States to insure hospital and medical care for indigents. Certainly the Federal Government and the States, with the demand by the public for adqeuate hospital service, will make provision for the financing of hospital service by public assistance where such assistance is needed for those unable to pay for the cost of their own care.

"We then believe that S191 warrants the consideration and approval of this committee and the Federal Congress. We believe it to be the most progressive type of legislation and eminently practical. There has been much talk of improvement in the field of health services with little knowledge of the true needs in this field. We grant that there are serious lacks in the present system of hospital service, and we believe that this proposed legislation providing for careful study of needs is the first step toward improvement.

"We realize that the total need as determined by State surveys may indicate the advisability of large investment by the Federal Government and the public. We believe this investment, insofar as the Federal Government is concerned, should be carefully geared to the need for a public-works program. The people of this country are firmly convinced that capital improvements in health under a public-works program are among the best investments which can be made by the Federal Government. However, such an investment made on a hit-and-miss basis without an over-all program can be a waste of public funds.

"This bill establishes authority in the United States Public Health Service and insures that Federal funds be allocated among the States in proportion to the need for health resources. Its passage will in our opinion be an excellent step forward by the Federal Congress toward solving the perplexing problem of supplying adequate hospital, health services, and medical care to all of the people."

DR. THOMAS PARRAN, SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE MADE THE FOLLOWING STATEMENT IN PART:

"When peace returns, this country should so reorganize and develop its health resources that there will be available to everyone in the population all health and medical services necessary to preserve and promote health, to prevent diseases, and to treat illness.

"I am especially interested in this proposed legislation since its enactment would constitute an important amendment to the Public Health Service Act of July 1, 1944, and would place additional duties and responsibilities on the Public Health Service. Passage of this legislation would do much to promote health conditions in this country.

"In my opinion, the bill before the committee, S191, has been soundly conceived. Broadly, its purpose is to assist the States in proportion to their needs in planning for and providing for modern hospital facilities which would be available to every citizen.

"As a first step, surveys of need for general and special hospitals would be made in each State under the aegis of responsible State hospital authorities. The surveys would precede the drafting of master plans. These plans would not be dictated by the Federal Government but would be formulated presumably by the most competent persons in each State. Community plans would be integrated into the State plan.

"Obviously such plans would be formulated around, and would represent an expansion of, the present hospital system. Equal consideration would be given voluntary and publicly owned institutions. Through the principle of variable grants, the more needy States would receive the larger proportions of Federal aid. Individual construction projects would be aided only if they were recommended by the State authority.

"An advisory council, composed of outstanding authorities in the health and hospital fields, would be given very definite responsibility in determining the Federal policies. A real partnership would be developed between the Public Health Service and State hospital authorities. This partnership would

follow the familiar pattern of present public health law which has worked so successfully in our dealings with State health departments. The amount of construction authorized from year to year would, no doubt, be varied and balanced with over-all budgetary considerations, employment conditions, and the urgency of need. When the program is in full operation, its beneficial effects will be felt by every citizen.

"A hospital-construction program also will provide modern scientific tools for the thousands of doctors who will be returning from military service. These men have become accustomed to the best and most modern medical equipment available and will not be content with a dingy office over a village drugstore. Furthermore, the hospital and health facilities which would be provided through the enactment of this bill, would encourage a better distribution of doctors during the post war period. Without the provision of these facilities on a more equitable basis throughout the country, the prewar maldistribution of doctors and their overconcentration in population centers would be aggravated.

"On July 12, 1944, I appeared before the Subcommittee on Wartime Health and Education of this committee, at the invitation of its chairman, Senator Pepper, to express my views on a number of war and postwar health matters. At the request of the subcommittee chairman, particular emphasis was placed on the importance of hospitals, health centers, and other health facilities in relation to the whole public health problem. Since then, Mr. Chairman, we have given considerably more thought to these problems, especially as to how they would be affected by the proposed legislation now before this committee. Moreover, there has been considerable public discussion and wide acceptance, on the part of all professions concerned, of the principles outlined in the interim report of the subcommittee.

"I should like at this time to present my views on the broad implications of S191 in relation to the national health.

"Hospitals and other health facilities assume an importance to the public health in direct relation to the technical advances of medical science. While the earliest hospitals constituted a curious admixture of religion, superstition, and primitive cures, the modern hospital is a complex, technical machine, employing the latest scientific diagnostic aids, preventive and curative measures, and professional skills. Within the memory of most of us here, the hospital was almost a port of last hope—I could almost say a port of lost hope. A large majority of the patients were admitted for emergency surgery. The others were often long neglected and far advanced medical cases. As a result, death rates were high. No self respecting woman would think of going to a hospital to have her baby.

"We are now witnessing a rapid change in the public attitude toward hospital care. No longer is hospital aid sought as a last resort. It is, instead, almost one's first thought in illness. Each year more than 1 out of every 10 persons are admitted to a hospital for treatment. Of 2,900,000 babies born in 1942, 2,000,000, or about 70 per cent, were delivered in hospitals. In some of the more health-minded communities the percentage of babies born in hospitals reaches nearly 100 per cent.

"During the relatively recent years in which we have seen hospital care grow in public favor, we have also seen public health in general take remarkable forward strides. Death rates from all disease causes have fallen to an all-time low of about 10 per 1,000. Infant and maternal death rates have also dropped correspondingly. Whereas only 25 years ago about 100 infants out of every 1,000 live births were claimed by death during the first year, the average rate is now but about 40 deaths in every thousand births. Where 25 years ago 9—9.2 mothers died for every thousand babies born, now less than 3.6 are lost. As a result of earlier hospitalization of illness, the length of stay in general hospitals has been gradually reduced to an average of about 10 days.

"Of course, not all advances in national health have resulted from better hospitals and their increased use. Many other factors have played a part, but there is no doubt that hospitals and other health facilities have played leading roles.

"The present hospital pattern of the country has been shaped by strong social influences. The hospital now is considered a part of the community on the same level as the church and the school. The hospital, especially the voluntary hospital, is steeped in traditions of service and sacrifice. These traditions are valuable assets for the present and future. They should be preserved and molded gradually to fit changing social requirements and scientific developments. The concepts underlying S191 are in harmony with these considerations.

"To understand the present hospital pattern of the country, one must look also to the motivation behind their establishment. We find that these motives have changed but little to the present day.

Since the Elizabethan poor laws, governments have accepted responsibility for the medical care of the sick poor. From earliest times, churches have cared for the sick as the natural expression of their charitable mission. Later, as hospitals were accepted by others than the sick poor, a new type of institution developed—a hospital, operated by and for the community.

"Actually, there is now little difference between church-operated and other voluntary hospitals. To a lesser extent, we also have the so-called proprietary hospital, conducted ostensibly for such financial profit as may be gained from its operation. In practice, therefore, there are 3 broad classifications of hospitals—the governmental, the voluntary nonprofit, and the proprietary. The hospital pattern of the country has grown around this three cornered framework, each of the 3 types meeting a special need. There are about 5,828 non-Federal hospitals now in operation throughout the country of a quality sufficient to warrant registration. These are divided as follows:

| CONTROL | NO. OF HOSPITALS | PER CENT | BEDS | PER CENT | AVERAGE CENSUS | PER CENT | PATIENTS ADMITTED | PER CENT |
|---|---|---|---|---|---|---|---|---|
| All non-Federal | 5,828 | 100 | 1,172,581 | 100 | 988,378 | 100 | 11,342,091 | 100 |
| State and local government | 1,457 | 25.0 | 799,466 | 68.2 | 714,986 | 72.3 | 2,230,220 | 19.6 |
| Voluntary nonprofit | 2,956 | 50.7 | 322,707 | 27.5 | 241,245 | 24.4 | 7,959,670 | 70.2 |
| Proprietary | 1,415 | 24.3 | 50,408 | 4.3 | 32,147 | 3.3 | 1,152,201 | 10.2 |

"Hospitals operated by State and local governments have 25 per cent of the total beds and handle about 20 per cent of the total patients treated; voluntary nonprofit hospitals have about 51 per cent of the total beds and care for about 70 per cent of the patients; proprietary hospitals have about 24 per cent of the total beds, with but 10 per cent of patients.

"The proprietary hospitals are the least important, both in number and number of patients treated. While they have filled important community needs in many places, they are least able to meet the rapidly growing community responsibilities and are steadily decreasing in number. It is clear, therefore, that the public health responsibilities which may be placed on the hospitals will be shared, for the most part, by the voluntary and governmental institutions.

"It may be helpful to the committee in considering S191 to anticipate the position of hospitals in the future public health structure. I refer, in this instance, to public health in its broadest sense. I believe that the hospitals now face a broader responsibility in their relation to society than ever before. Acceptance of this broader responsibility involves new concepts and new philosophies. It is apparent that the leaders in the field are aware of this and stand ready to make the necessary adjustments.

"Hospitals in the past have been dedicated primarily, if not exclusively, to the treatment of disease. Relatively little thought has been given to its prevention. I believe the general hospital of the future will have a much wider function and will have a much closer relationship to the whole problem of national health. For example, in our social structure, certain obligations and duties have been assigned. Government, generally speaking, has assumed responsibility for the care of long and expensive types of illness, especially where these illnesses constitute a hazard to society such as tuberculosis, mental illness, and contagious disease. Also, to agencies of Government has been delegated responsibility for the protection of the public health through the creation of a sanitary environment, protection against the spread of communicable disease, special care for children and for the aged.

"More recently, the concept of public health has expanded to include treatment of disease and disability in the individual. The voluntary agencies and hospitals have accepted the task of caring for those able to pay the cost of their care, plus those charity cases for which government could not, or would not, accept responsibility. As between each of these fields of endeavor, there has been overlapping of duties and often wasteful duplication. We have arrived at our present situation with little conscious planning. I feel that a great deal more integration of effort must now be brought about. While public and private fields of influence in health care will, no doubt, be retained, and I think desirably so, it becomes increasingly clear that there is no hard and fast dividing line. The voluntary hospitals, although private in organization, are at least quasi public in function. Society has recognized this fact in giving them immunity from taxation. In other words, they are performing a service which otherwise would

have to be provided by government. Any national health program, therefore, should recognize and utilize to the fullest the large financial and human investment in voluntary hospitals. S191 provides for such recognition and utilization.

"Earlier, Mr. Chairman, I discussed some of the public health progress made in recent years. This progress is extremely gratifying, but much remains to be done. Nor has this progress been uniform throughout the country. On the contrary, it has been somewhat spotty. Although the infant death rate averages forty—40.2 per cent—per thousand live births, in some States it is still more than double that figure; although in some States nearly all the babies are born in others, the rate is as low as 21—21.5 per cent—and a high percentage of the others are delivered by midwives; while a few States have hospital beds up to or above minimum standards, many are considerably substandard. Even in those States with an over-all adequate number of hospital beds, maldistribution leaves many communities poorly served. Altogether, there are about 1,200, or 40 per cent, of all the counties in the Nation without any recognized hospital facilities. These counties contain more than 15,000,000 people. While not all these counties could support, nor should have, complete hospital facilities, there is little doubt but that each of them could support, and should have, some type of health center equipped perhaps with a few emergency beds, and especially with ordinary diagnostic facilities available both to the public health officer and to the rural doctors.

"Reasons for inadequate hospital facilities and for their inequitable distribution are not difficult to determine. In the first place, hospitals are expensive to build. In the second place, a good hospital requires a high concentration of professional skill. Both these requirements are found most abundantly in the wealthier States and in the metropolitan areas of all States. As we go farther away from these centers of concentration, hospital beds become fewer in number and almost invariably poorer in quality from the standpoint of professional service. This is due to the fact that the average small community cannot afford the services of the several types of specialists and expensive equipment required for a complete medical and hospital service.

"Only a part of the potential health value of a hospital lies in its service to bed patients. In the aggregate, perhaps, its value is even greater to the community at large. While only about 11 per cent of the population has occasion to be admitted to a hospital during any one year, many times that number require the services of a physician. The presence of hospital and diagnostic facilities, possibly more than any other factor, determines the distribution and professional skill of physicians. This fact is demonstrated in a rather striking manner by some studies recently carried out by my office. It was found that areas having an average of 4.6 general hospital beds per 1,000 population had, just prior to the war, 166 physicians for every 100,000 persons, while in areas where there was less than 1 hospital bed per 1,000 persons, there were only 77 physicians for every 100,000 of the population. It is estimated that a ratio of at least 100 physicians to each 100,000 persons is required to give a reasonably adequate medical care. It is seen, therefore, that even before the war, communities with inadequate hospital facilities also had inadequate medical service.

"Moreover, this does not tell the whole story. Almost invariably, in the communities with substandard hospital facilities, a large percentage of the doctors are in the upper age brackets and, consequently, are less active. Young physicians are trained in hospitals, and they will not settle in communities lacking facilities essential to modern medical practice.

"While public health properly embraces all medical science, it heretofore has been practiced primarily as the science of disease prevention. Early public health efforts were confined largely to the enforcement of quarantine regulations and to the abatement of nuisances. For those duties, neither much skill nor much equipment was required. As a result, the quality of public health personnel was poor and the quarters of the health department were almost invariably in the least desirable public space available. In the past 25 years, great changes have occurred in many aspects of public health; in others, very little. The quality of personnel has improved immeasurably. Public health is now a recognized specialty, based upon medical science, but utilizing many other highly technical skills. To augment the efforts of the health officer, there has been developed a highly trained corps of clinical specialists, public health nurses, dentists, sanitary engineers, entomologists, and techicians. From quarantine and nuisance abatement, the accepted functions of public health officials have come to include such activities as protection of food, milk, and water supplies, immunization against contagious disease, well-baby clinics, detection and treatment of tuberculosis and venereal disease, clinics on nutrition and on mental diseases.

"The technical progress of public health, while brilliant as a science, has, even more than hospitalization, been uneven in its application, although grant-in-aid funds provided under the Social Security Act of 1935 have helped to spread public health services more evenly throughout the Nation. There are still many areas, however, in which many essential health services are nonexistent. In fact, we have barely scratched the surface in affording modern health protection to the people of this country. S191 deals with one important aspect of this problem. One obstacle to public health progress is poor housing provided for our local health departments. Outside of some of the larger urban areas, modern, or even reasonably adequate, public health clinics, laboratories, and administrative offices are but rarely seen. Quarters in courthouse basements and discarded buildings are the rule rather than the exception.

"Largely as a result of this condition alone, public health departments have not attained the community stature their importance warrants. Until this condition is relieved through the provision of modern health centers, improvement in our public health services will be retarded.

"In the foregoing, I have tried to outline in general terms some of the problems now facing the public and private health agencies. I am convinced that a first step toward a solution of most of these problems requires improved health facilities soundly planned and better distributed.

"In the depression years funds for construction both from private philanthropic sources and from tax sources were sharply curtailed, and there was relatively little hospital construction. During the war years, construction has been even more sharply limited. As a result, we face the post war period with a very large accumulated need. Upon this, we have superimposed a greater demand than ever before. I think we must plan to meet these needs through a controlled integrated expansion of our hospital and public health facilities.

"Last July, in my testimony before the subcommittee, I outlined an integrated hospital system which would not only extend hospital and other health services to all parts of the country, but would assure a high standard of professional service even in the smallest institutions. Admittedly, most of the elements of the plan were borrowed from leaders in the hospital field. Briefly, the plan I have in mind is predicated upon four types of institutions: Medical centers or base hospitals, district hospitals, rural hospitals, and health centers.

"The medical center, wherever possible, should be a teaching hospital of a university medical school. In addition to its usual hospital and basic teaching and research functions, this institution should make arrangements to furnish the most advanced diagnostic service to the other hospitals in its area. It should also be in a position to give refresher courses to practicing physicians and to offer consultative and complicated treatment service to outlying district hospitals.

"The district hospital would be a typical, well organized general hospital of perhaps 200 to 500 beds, without the medical training and extensive research facilities of the medical center. It should be, in addition, the service nucleus upon which the surrounding rural hospitals and health centers would depend for much of their diagnostic, consultative, and complicated treatment services. These district hospitals would train interns, residents, nurses, dietitians, and technicians—desirably by interarrangements with the medical center. Services of these personnel, moreover, might well be made available to the rural hospitals as a part of the training program.

"Rural hospitals would be mainly those of 100 beds or smaller. Our present rural hospitals, by and large, have many handicaps to the giving of efficient care. Frequently, they are too small and too poor to maintain many of the essential services such as x-ray, pathology, and clinical laboratories. Rarely do they have available the services of specialists. These hospitals need the help of the larger, better equipped institutions. It is in the rural communities, too, that many of the new facilities are required. In the rural hospitals, in particular, I feel that a closer coordination of all health services is most essential. One properly designed building could well house both the hospital and the public health department to the mutual advantage of both. It might also, to advantage, furnish office space and diagnostic facilities for the rural physicians.

"Health centers, the fourth element in the plan, likewise may serve a dual purpose. Where hospital facilities are already available, the health centers would serve primarily for public health clinic, laboratory and office space. They might also meet another pressing need. There are many small, relatively isolated communities in dire need of some type of hospital facility. These communities are too

small to either finance or maintain a fully organized and equipped hospital. A relatively inexpensive health center, with possibly a few emergency beds, diagnostic and treatment facilities seems the only reasonable aswer to this problem."

DR. R. L. SENSENICH, MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION MADE THE FOLLOWING STATEMENT IN PART:

"The board of trustees of the American Medical Association has given careful consideration to the provisions of the Hospital Construction Act in the light of the platform of the association. . . .

"The board at a recent meeting took action to the effect that so far as its general policies are concerned the Hill-Burton bill is within the platform of the American Medical Association; that while there are certain modifications that would better define some of its provisions and render the bill more effective, nevertheless, it is the feeling of the board that the bill in general should receive the support of the American Medical Association. That is rather a formal statement by the board and does not convey fully the appreciation of the board of this effort to provide legislation of a kind that will be helpful and I have given copies of this platform to you which will give you some idea of other points included in our basic consideration. . . .

"THE PLATFORM OF THE AMERICAN MEDICAL ASSOCIATION

"The American Medical Association advocates:

"1. The establishment of an agency of Federal Government under which shall be coordinated and administered all medical and health functions of the Federal Government exclusive of those of the Army and Navy.

"2. The allotment of such funds as the Congress may make available to any State in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.

"3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

"4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

"5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

"6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

"7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

"8. Expansion of public health and medical services consistent with the American system of democracy.

"The authors of the bill, and their advisers, are to be congratulated on the basic soundness of their approach.

"The platform of the American Medical Association with regard to the extension of medical care includes the recommendations that funds allotted by Congress 'for the prevention of disease, the promotion of health, and the care of the sick' should be based on 'local determination of needs and local control of administration.' That is a part of the platform and quoted from it.

"In this bill there has been full recognition of the fact that conditions relating to health and hospital problems vary tremendously in the different parts of the country. That has been developed in the discussions of the committee again and again, and I am sure it is not necessary to make that statement.

"A hospital construction plan for a populous, highly urbanized Eastern State may be utterly unsuited to a sparsely populated State of the Rocky Mountain area. Neither of these may be adpatable to a prosperous corn, hog, farm State or an economically ill favored tenant-farmer State. The Hill-Burton bill appears to provide a maximum of flexible adaptation to local conditions; with a minimum of undesirable uniformity and regimentation. We are very much interested in the matter of approach to the problem of hospital facilities from the standpoint of giving consideration to the local need. In addition to the actual care of the sick, there are many other things which must be taken into consideration; the habits of the people with reference to their trading, and not infrequently we find they go in the opposite direction from the place in which you have established their facility because their normal line of traffic is in that direction. They take their produce there. They buy their supplies there and their funds are banked there, so that all of these

things, while they seem to be very small in themselves, yet they are quite important to the problem of the local community. . . .

"With reference to the qualifications, if I may proceed, it might be desirable to consider a rewording of the provisions for these appointments. This refers to the Federal Advisory Council, so that lines 24 and 25 on page 14 and lines 1 and 2 on page 15 might read: 'Eight appointed members shall be persons who are representative outstanding authorities in fields pertaining to hospitals, public health, and medical care activities, and a majority of them shall be representative authorities in matters relating to the operation of hospitals.'

"The reason for suggesting that term is that 'health' is a very broadly used word and it may cover a field which is almost entirely foreign to the actual administration of hospitals and the provisions of medical care, not infrequently educational activities. At the present time I am interested in this program for physical fitness of the so-called joint committee of the American Medical Association, which is an effort to advance the education and stimulate interest in physical fitness and, broadly speaking, that is a physical activity, yet some of those people most useful in that field would obviously not have had experience in hospital management and the care of sick in hospitals. . . .

"In the consideration of the bill before the committee, the question of Government contribution to maintenance was discussed, where the location of a facility is determined on the basis of medical needs. I listened with great interest to that the other day. What are you going to do if the medical needs of the community justify the facility there and the community has not a sufficient number of people, we will say, financially able to maintain it? That was discussed by Senator Pepper and Senator Taft, I believe, and others. It must be recognized that, after all, you are providing machinery here for the creation of hospitals for all the people. You are going into communities where there are no facilities and in each community there will be both who are unable to pay for hospital care as well as those who are able to pay. Let's recognize that this is of the character of a public-utility period. It is an almshouse, on the one hand, and it is not a place for the rich on the other. It is, to my mind, the nonprofit, voluntary association hospital. I like to call it that. That is the real name in most States and is really the purest form of democracy. An institution is built up in a community. Its board is made up of outstanding citizens of the community who have the respect and the confidence and the ability and who give their time without pay to the operation of a hospital which has no tie-up with any political group. These people offer to give their services for the maintenance of a facility to care for the richest man and the poorest man and the poorest baby, and all the way through, and the record of those voluntary association hospitals is outstanding.

"I do not want to quarrel with the Government, but I should say that the general average and certainly the results in these voluntary association hospitals are second to none. I make no exception and they are far superior to some large numbers of Government facilities, so that what we want to do here is not to alter or to destroy the operation of the voluntary association hospital.

"The question arose the other day about what was going to be done if the thing was liquidated. I never heard of such a thing. There may have been one such a time. As a matter of fact it does not belong to anybody. It has no stockholders, it has no stock outstanding. The board selects its successors, of course. They are supported by public contributions paid by the sick and frequently from tax sources as well, so they are not subject to any kind of the accidents, we will say, that happen to a good many political local units.

"However, the facility is established for all the people. Illnesses differ and provisions for treatment must meet the particular needs. Tuberculosis requires special hospitals, long hospitalization, and some measure of isolation. Most tuberculosis hospitals are owned and supported by State or county units of government. County tuberculosis hospitals frequently are reimbursed from State funds at a fixed amount per patient per day. In other words, I should dislike to have this bill involved in some financial plan whereas here is something which is already provided for. If they need assistance to increase those facilities then this is the proper place to receive that assistance, but beyond that its financing should be done locally. Personally, I do not like the idea of a local community not making any contribution to the care of its own citizens and then constantly appealing to the Federal Government for funds.

"The care of the insane has long been recognized as the direct responsibility of government. Again, there might be a situation in which funds might be

asked for an insane hospital. I do not think anybody has ever questioned that. They are cared for at government expense.

"Chronic illness of other types, especially the slowly progressing illness of the aged, requires long periods of hospitalization and beds cannot be given over for these patients in hospitals planned for the care of acute illness. The aged person, having suffered a cerebral hemorrhage and paralyzed on one side, may live for years, cannot be permitted to occupy a bed which should be available for the individual with an acute appendix who must be operated on and who will be in the hospital for 8 or 10 days, and the mother in childbirth; those are acute cases. Something else should be done with the individual with advanced cancer who is going to live for a considerable period of time, the old nephritic, the old heart case; that is a different category entirely. No doubt this fact will lead to the eventual establishment of more special hospitals for chronic diseases. It costs less to operate. You do not need all of the facilities you need for acute illness. Some units of government must support the indigent in these hospitals. State and local governments may be stimulated to accept their full responsibility.

"A study of the indigent group reveals great concentration of chronic, incurable diseases, the crippled and the mentally inadequate. That seems to be news to a lot of people in the matter of discussion, and I dare say you can go out to the charity hospital today and, unless they make an effort to screen their admittances, you will find that that is about all there is in the hospital today, the chronic illnesses, and, of course, in the group of indigents not confined to hospitals are the mentally inadequate and the crippled.

"We are taking care of the blind with certain Federal funds. There is another point there I have not touched. Some machinery probably should be set up whereby they are assured medical care when they are ill. They are given a certain amount per month, but there is no special provision made for them when they are ill or, at least, not enough. . . .

"This bill includes under the definition of hospitals, public health centers, and general, tuberculosis, mental, chronic disease, and other types of hospitals and related facilities, very comprehensive, and so it should be. It is sufficiently flexible to be useful in whatever portion of the field of hospital care that need is demonstrated. It may, therefore, provide special facilities for many of the varied types of the chronic-disease indigent groups.

"The American Medical Association is primarily interested in the best medical care for all the people. It would seem inadvisable to attach to this bill any plan for financing maintenance such as would render the bill less flexible and impair its effectiveness in providing facilities for different groups under varying local conditions.

"The bill now provides the means for the development of facilities for the best hospital care for all the people on the basis of needs as determined by investigation and by careful planning to meet those needs."

# INDUSTRIAL REHABILITATION

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NOT ALL the presumably new words which have recently gained wide circulation have had their origin in the war. In the days of the Romans, there existed such a word as "habilitare," which meant "To make fit or restore to normalcy." The syllable "re" preceding this word has the meaning "again;" hence, their word "rehabilitare" signifies "restoration to one's former condition or status as far as his emotional and physical stamina is concerned." After centuries of usage the term has retained its original meaning, but the complexion of its present day connotation is somewhat altered. Today, it seems to be restricted to those with physical and mental disabilities received at the fighting front or in industry.

It is a veritable benediction that so much attention and effort are focused upon returning the incapacitated soldier or laborer to a position wherein he can feel that his contributions to industry are as essential as those of his more fortunate fellow workers who have never been the victims of physical or mental handicaps. Rehabilitation carries a twofold blessing; one to the employer who has assisted in a man's restoration; the other to the recipient of this attention because it makes him realize he is not an object of charity, but a real participant in the battle of life. One of the greatest challenges today to industry and to industrial medical organizations, after peace has been won, is rehabilitating the disabled veteran.

The term, "disabled veteran," is not confined to those wounded or injured by shell fire on the fighting lines, but likewise to those on the home front, who have contributed so much to make victory possible. Rehabilitation is our problem and we must meet it resourcefully, restoring the handicapped to as thorough a physical, mental, social, vocational and economic functioning as his capabilities permit.

War conditions have definitely proved that man can be readily rehabilitated. It has been possible to take men from all paths of life, to completely change their mode of living, their occupation, their social and economic sphere; in short, to readjust them so that they may fight, work and win the greatest war of all time. This being true, the rehabilitation and restoration of the physically disabled are a foregone conclusion. The war casualties will be well on their way to recovery when they are returned to civilian life, and ready for employment and it should be and is the aim of industry to carry on and complete the work already begun.

In order to evaluate accurately a candidate for rehabilitation, we must consider first, total-temporary disability. Such cases as fractures, dislocations, lacerations, digital amputations, strains, etc., are usually of short duration as indicated by an early return to work. Secondly, we must consider permanent disability. This embraces a very small percentage, and, for the most part, progress is frequently retarded by unnecessary litigation control. Thirdly, we must take into account the partial-temporary disability, the victims of which rehabilitate themselves quickly because they are kept on the job, and consequently, do not become neurotic or hypochondriacal. And fourthly, there is the partial permanent disability which calls for definite rehabilitation carried out through surgery, vocational training, physio-therapy, massage, hydro-therapy, etc.

Larger industries for the most part have become medically business minded, and have come to realize that their interest in the employee goes much further than the treatment of injuries arising out of, and in the course of, their employment. Such cases, according to estimates made, account for only 7 per cent of industrial absenteeism; occupational diseases cause but 3 per cent, while 90 per cent of the absenteeism is due to sickness of non occupational origin. This realization has caused industry to evaluate its manpower by periodic physical examinations as well as by replacement examinations, and has taught it to accept rehabilitation as a paying policy. Otherwise, business must expect to be confronted with more and more regimentation through taxation. This re-

*Address of the retiring president, New Haven County Medical Association, New Haven, April 26, 1945*

habilitation, for sound economic reasons, applies especially to the smaller industries which predominate in American production, and which lack well organized medical supervision.

Most large industries have a well functioning medical organization and hospital equipment, with efficient nurses and attendants, and a medical and surgical consulting list, made up of specialists. Pre-employment physical examinations are made, and follow up records are kept. Surgical rehabilitation will call for plastic, reconstructive, remedial, reparative, neurological, orthopedic, genito-urinary, and dental surgery. Medical rehabilitation entails a thorough examination of the cardio-vascular and cardio-respiratory system as well as a detailed study of the metabolic diseases. Neuropsychiatric rehabilitation, consists of psycho-analysis, psychoneurotic adjustment, and the treatment of psychosomatic diseases, functional disturbances, cerebro-spinal lesions, and the evaluation and control of epilepsy.

In traumatic disabilities, when a man is injured one of four things ensues, a pathology is created which may be a partial, a partial-permanent, or a total-permanent disability; an aggravation of a pre-existing disability is caused which may render a man partially or permanently disabled; it may precipitate the symptoms of some latent process which may result fatally; or accelerate a pre-existing pathological condition. It is essential, therefore, that thorough pre-employment, periodic and replacement examinations be made so that candidates for rehabilitation will have a complete and accurate evaluation of their physical status. When a physically handicapped man is placed successfully, he ceases to be a handicap from the standpoint of his productive ability and his earnings.

It is the duty of the examining physician to outline in detail the disabilities which make the employee unsuited to certain types of work, and to point out the danger of employing a physically handicapped man in fast moving machinery or heavy lifting. There are certain men who should work only on ground level and there are others who should avoid dust and fumes.

With regard to the tuberculous employee, little need be said. In the sanitariums of the state of Connecticut, the training and education of the patients render them well able to cope with their disabilities. In fact, these institutions have been virtual pioneers in the field of our present day rehabilitation.

Readjustments will be difficult. This we must anticipate. It will be hard to rehabilitate the young veteran, who has learned no trade but war. He is a stranger to the ways of making a livelihood. It will be a problem for men returning from the battle fronts to find their places in a world at peace. The person who has been forced to discontinue his educational career or vocation, and who through some physical handicap will not be able to achieve his ambition, will challenge our supreme efforts to bring about his restoration. A commissioned officer will find it difficult in many instances to return to his former employment, and pre-war status. The psycho-neurotic will probably be readily rendered fit, but it should be kept in mind that this type of individual is a tremendous risk, in view of his reaction to injury. In many cases industry will hesitate to employ him because of his instability and our present compensation laws. The psychosomatic problem must extend into the lives, homes and social contacts of the individual in order to successfully bring about a return to normal personality. There will be cases that cannot be successfully rehabilitated and these must be considered mifits.

Readjustment must be made through group organization. The medical program must be closely associated with the personnel department of industry and must have the whole-hearted cooperation of supervisors, foremen and others who are in close contact with the returned veteran or disabled employee. Only through the combined efforts of the industrial executives, labor managers, foremen, educational leaders, and medical groups can rehabilitation reach fruition, and gainful employment and other opportunities permit disabled men to resume their rightful places in society.

Candidates for rehabilitation must be free from the symptoms either of some physical disability or of a functional disturbance. They must be happy in their work, with a job that gives them a sense of satisfaction and an assurance that they are an essential part of the organization employing them. They cannot and will not succeed if patronized, for such treatment precipitates á sense of inferiority, which, in turn, is followed by a loss of confidence in others. They must have neither mental conflicts nor mental hazards which will interefere with their efficiency and their power of concentration. They should have a satisfactory home environment and sufficient recreation to preclude monotony. They should never be considered cripples or disabilities upon whom foolish and dangerous sympathy is expended, nor should they be encouraged to exploit their

physical handicaps at the expense of their work.

During the period of adjustment the applicant for rehabilitation should be examined and checked for physical incapacity by a physician, until successful results have been attained. Recovery actually starts in the hospital by getting the sufferer out of bed in the quickest possible time and by corrective exercises and supervised physical and recreational activity.

Chronic invalidism is often caused by allowing a patient to remain in bed too long. He becomes king of a little universe that revolves about him. It is imperative to replace fear and depression with confidence and optimism. Fractures, in particular, should be out of bed as soon as practicable, if necessary on crutches or with the aid of a perambulator. When possible the use of the walking iron or of the various calipers is to be advocated. Too long immobilization of fractures is productive of permanent disability. Manipulation, traction and counter traction should be instituted early in all cases of contractures, particularly after severe burns of the extremities and of the digits. Early skin grafting and the application of active and passive motion to the burned extremities are definite means of early restoration of function.

Readjustment following the last war was for the most part a decided failure, largely because it attempted to segregate the injured in institutions, or to give them a financial bonus, or to divorce them from activity by awarding a lump sum settlement for a permanent disability. How much better it would have been to adapt, when possible, such individuals to industry or to business. It would appear only fair that industry should be protected from the possible breakdown of the rehabilitated veteran whose disability actually is the result of service in our armed forces. Restoration of our returned veterans must be interrelated with the problem of post war reconstruction of the entire economic system and not made independent of it. It must be protected from the influences of political and industrial expediency. This result can best be obtained under the guidance of a doctor of medicine.

Industrial rehabilitation can be successful only with the full cooperation of the family physician, who should be considered a necessary counselor in securing the confidence of the disabled employee. Under no circumstances should industrial medical organizations fail to maintain the professional code of ethics. The program of rehabilitation should never trespass upon nor transgress the rights and privileges of the private physician.

Industry should not be considered as attempting to practice medicine or surgery, but it is sound business to place and maintain an employee at work sutiable to obtain production with maximum mutual satisfaction to both employer and employee. The attempt at rehabilitation should not be construed as socialized medicine, but rather a plan to minimize the danger of regimentation both in industry and in the practice of medicine.

Neurosis is born of worry, and rehabilitation is virtually a promissory note to the injured that they will eventually be returned to their social and economic status in the business world. The workman should be encouraged not only to look to the plant physician and his nurses for treatment of his compensable ailment, but to consider them also his confidants and counselors. Thus, by the proven methods of intelligent rehabilitation will he find himself entering upon a happier tomorrow.

## A COMMENT ON INDUSTRIAL REHABILITATION

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YOU MAY wonder why a mere manufacturer, one of the lowest forms of vertebrates, has the temerity to stand before you and comment on the excellent presentation of a most perplexing problem just submitted by Dr. Jackson. However, "fools rush in where angels fear to tread," and occasionally the Goddess of Luck follows them—but usually at a safe distance. So at the outset let me state that any ideas or opinions that I may voice are my own, based upon somewhat limited experience, and do not reflect the policies of my employers or my community.

It is true that industry has become medically minded, just as it has become interested in air con-

ditioning, horse racing or any other influence affecting the welfare of its employees and the cost and quality of its product. When a new process or a new tool is developed, industry immediately gives it a tryout, just on the chance that it might be an improvement on existing methods. So when our medical men come forward with a program which may improve our human equipment, it is only common sense to give it a run for our money and let the results speak for themselves.

Now we wouldn't think of buying a tool without securing the builder's recommendation concerning its capabilities and limitations. In the case of the employee, Dr. Jackson or some member of his organization must write the specifications and it is to him that we must look for the technical information which is of vital importance to us in relocating the injured worker or placing the returning veteran in a satisfactory and productive job. Towards the end of his paper, the doctor not only assumes this job but also is willing to inter-relate it with the problem of post war reconstruction of the entire economic system. This sounds to me like a rather large order.

For the most part business has no moral sense, as such; by that I mean its willingness to support individual and community welfare projects stems only from its desire to do a better job for its owners and hence receive a higher return for its labors. This is the fundamental basis on which we justify heavy contributions for research, education, hospitals, community chests and other activities of that general character.

A grateful Nation, acting through its Congress, has provided extensive rights and benefits for its veterans, including a chance at the "old job," if they so desire, are able to swing it and it is available. In New England, it is estimated that from 20 to 60 per cent will return to their former employment. Fitting these men back into organizations which may be going through a violent reorganization or retrenchment, is a job which no one can plan in advance except in the most general terms, but knowing that it will come, it is folly not to make as much preparation for it as we can.

Industrial policy would seem to fall into three fundamental divisions: We haven't got the veteran yet but we have got the job, so the *first* step is a thorough understanding of our own work in all its departments or so-called "job evaluation." By that, I mean a thorough study of all operations within a given industry and their possible combination or recombination into what, for want of a better term, is called a job.

*Second*, is the training and education of our supervisory force. This is perhaps the most important part of the program, as the foreman, assistant foreman and group leaders are the men who from every angle are closest to the workman once he has taken up his duties. They have not only got to be representatives of management, but bargaining agents for management with Unions and stewards, also experts in the many techniques of production, and last but not least, interns acting for and on behalf of the medical and surgical director and his staff.

*Third*, is a definite plan for cooperation with veterans' and community organizations, including Unions, if they are in the picture. This is very important as no industry can prosper except as its community prospers, and no industry is strong enough to handle the many problems of reemployment without the assistance and cooperation of these other organizations.

Having prepared the ground as well as we can along these lines, our veterans begin to come back to us. Of course, many of them are normal, well adjusted citizens (whatever that is), but many others, to say the least, will have a very mistaken idea of what the country as a whole, and the community and industry from which they came in particular, owes them and can do for them.

Entirely aside from reemployment, the job of adjusting this latter group to life in a world which is essentially the same as it was when they left it, is one which the community, employer and all social and professional advisory services must share. This, in itself, is going to result in a period of unhappiness for many and by the time they decide that the honeymoon of their return is over and get around to the employment bureau, they will be none too happy and will be prepared to exhibit one or more of the various degrees of psycho-neurosis which we have been told are in store for us. Restlessness, unruliness, isolationism, disillusionment, we have had them all to cope with for a hundred years or more, long before we knew them by their scientific names, and perhaps some of you remember Kipling's poem the "Chant-Pagan," wherein he describes the reaction of the Tommy to his return to England following the South African War in 1902.

> Me that 'ave been what I've been,
> Me that 'ave gone where I've gone,
> Me that 'ave seen what I've seen—

'Ow can I ever take on
With awful old England again,
An 'ouses both sides of the street,
And 'edges two sides of the lane,
And the parson an' "gentry" between,
An' touchin' my 'at when we meet—
Me that 'ave been what I've been?

Let us assume that a veteran has announced his desire to go to work again and has been carefully examined by Dr. Jackson and his staff. We have a pretty good idea just what his limitations are and know from our records the kind of work he previously did and wants to return to. Let's suppose that he was an annealer and, by the Grace of God, the orders on file in our employment office show that we need an annealer, perhaps in the same department and even on the same furnace at which he previously worked. Everything starts out well and for a few weeks reports are good and the man seems to be happy. Then word comes in that he has become morose, wanders around the plant talking to and interfering with others; he is habitually late and is absent often and without any good explanation.

Mindful of Dr. Jackson's injunctions, we check up outside the plant and find that his home environment is deteriorating. His wife does not know what has come over him and the police are apprehensive because he has purchased a second-hand motor cycle, equipped it with all the trimmings he can find, and is tearing around the town endangering life and limb. We check up on his war record and find it reads as follows: "Enlisted January, 1942; assigned to tank corps; sent to North Africa; in every major engagement through to Kaiserine Pass—where tank blew up and he received extensive second-degree burns and shock; hospitalized first in Algiers, then at Halloran General, Staten Island. Discharged "O. K." But he just can't sit and watch a furnace. Good Heavens, of course he can't; he was in one! So he's out on the streets driving his tank again. Fortunately, we were able to transfer this man to the operation of a small gasoline powered mill truck with a loud horn. Now he is happy driving back and forth on a fixed route, handling cold metal and earning less pay than he received as an annealer.

Now, could or should Dr. Jackson or a capable psychiatric consultant foretell this result, or can they now foretell the next development? Can they say that we are helping or delaying ultimate recovery—and what should we do with this man when, and if, he gets tired of the truck?

What it all comes down to, in my humble opinion can be summed up in the words *patience*, *understanding* and *resourcefulness*. We must know the characteristics of every job in our mills; we must have a supervisory staff who have the correct approach to and understanding of the problems, and we must correlate each individual's problems with the community. We must also take advantage of every lead which the medical profession in all its branches can give us, and refuse to be discouraged by the many failures which are bound to occur.

## SCRUB TYPHUS

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Lt. (j.g.) Thomas C. Seymour, MC—USN, *Chatham, N. Y.*

This report concerns an epidemic of Tsutsugamushi Disease, popularly known as Scrub Typhus, which occurred on a southwest Pacific island during the months of June and July 1944. To the best of our knowledge this is the first epidemic of Scrub Typhus involving only naval personnel. Many cases among army personnel were found in New Guinea and more recently in the Schouten Islands Group.

According to Stitt, the etiological agent of the disease is a Richettsia, variously called R. Niponica, R. Tsutsugamushi, and R. Orientalis. The virus is transmitted only by the bite of certain larval mites, in this region the Trombicula akamushi, a red mite resembling the "chigger" found in the southern part of the United States. The epidemiology of this outbreak has been reported by others, so no attempt will be made to discuss this aspect. Further, no attempt is made to review the literature because of the lack of medical journals at this advance base. Our report will deal entirely with our own clinical findings.

All these cases of Scrub Typhus, twenty-one in number, occurred on one small island about 40 miles

from this base. It was impossible to determine the incubation period because none of the patients remembered having been bitten by a mite. Since about one-third of the cases had been on that island about two weeks before the initial symptoms, it was believed that the incubation fell within that period.

The disease was characterized by a moderately abrupt onset with headache, general malaise, generalized aches and pains, and gradually increasing fever. The following is a list of complaints, in order of importance, including early and late symptoms.

1—Headache
2—Anorexia
3—Weakness
4—Generalized muscle pain
5—Backache
6—Post-orbital pain
7—Chills
8—Deafness
9—Lethargy
10—Nausea and vomiting
11—Diarrhea
12—Constipation
13—Cough
14—Sore throat
15—Dyspnea
16—Photopsia
17—Pain on upward gaze

The headache was usually post-orbital, very severe and lasted about 5 to 7 days. Generalized aches and pains occurred very commonly, backache being a particularly severe complaint. Impaired hearing occurred in 14 of our patients, and when associated with the other symptoms, is almost pathognomonic of the disease. The deafness lasted from 2 to 30 days and recovery was complete in all cases. Chills occurred in about one-third of the patients and was usually described as a chilly sensation rather than as a severe shaking chill. Practically all cases were constipated during the course of the disease, requiring catharsis or enemata. Three cases had diarrhea at the onset, but this was an unusual finding. Four patients had nausea and vomiting at the onset, but this subsided after one or two days. About one half of the patients complained of a dry non productive cough, and five patients had definite dyspnea. As would be expected from any severe illness, practically all patients had anorexia and weakness.



Plate I. Scrub-Typhus

The physical findings are listed below:

1—Fever
2—Generalized glandular enlargement
3—Primary lesion
4—Prostration
5—Bronchitis
6—Pneumonia
7—Bradycardia
8—Low blood pressure
9—Skin rash
10—Orbital pain on pressure
11—Coated tongue
12—Conjunctival injection
13—Injected pharynx
14—Enlarged spleen
15—Enlarged liver
16—Abdominal distention
17—Tachycardia
18—Lethargy
19—Deafness
20—Slurred speech
21—Impaired memory
22—Tremor of hands
23—Delirium
24—Cyanosis
25—Peripheral edema
26—Pericarditis
17—Pleural effusion
28—Abdominal fluid
29—Mouth lesions (monilia, sordes, herpes)
30—Jaundice

All patients had temperatures ranging from 100° to 104°, persisting for 10 to 21 days and then gradually falling to normal. Characteristic of the disease is an eschar which was present on 19 patients. It was usually about 1 to 2 cm. in diameter with a black crusted center and represented the portal of entry of the richettsia (Plate I).

In areas where the skin is moist, such as the penis, scrotum or inguinal fold, the black crust may not be present. The eschar was still demonstrable in some cases as long as 40 days after the onset, but it usually disappeared by the end of the third week. Practically all the cases had generalized lymphadenopathy, involving particularly the femoral, inguinal and axillary regions and lasting 7 to 10 days. The lymph nodes draining the site of the primary lesion were usually the largest and most tender. Lethargy was profund and characteristic of the more serious cases. All but two cases had pulmonary findings consisting of many coarse and fine rales at the lung bases, and ten cases developed pneumonia of one or both lower lobes, proven by x-ray. Penicillin, 300,000 units, was given to three patients with no effect on the temperature or pulmonary findings. The pneumonia is most likely of rickettsial origin. Only about one half of our cases had enlarged livers and spleens, and these were quite soft and tender on palpation. Because of the softness of these organs, and the tenderness and distention which many patients had, it is likely that some were overlooked. Practically all patients had a relative bradycardia, the average pulse being 90 with temperatures

about 103°. Tachycardia occurred at the onset in 4 patients and after the onset of pneumonia in 6 others. All patients had a mild hypotension, the average blood pressure being 95/60 early in the disease, and about 115/75 in convalescence. Only eight patients had a typical rose colored, maculopapular rash, scattered over the chest, abdomen, trunk and extremities. Two other patients gave a history of having had a rash, but this had disappeared at the time of admission. The rash usually appeared between the third to fifth day of the fever and was very evanescent in character. Photophobia, conjunctival injection, coated tongue, cyanosis, peripheral edema, pericarditis and pleural effusion, were other inconstant findings. One patient had petechiae on the feet.

The laboratory findings were quite characteristic. There was invariably a leukopenia with increased lymphocytes in the differential counts. The red blood counts showed considerable anemia, usually occurring after the defervescence of the fever. Sedementation tests were done frequently on all cases, and the rates were markedly elevated. This persisted well into convalescence, and it was felt that the sedementation rate was a good guide to follow in determining when to allow a patient out of bed. Bleeding and clotting times were done and showed only minimal variations from normal. A bone marrow smear was made on one patient who had a severe anemia and no abnormality was noted. Weil-Felix agglutinations with proteus O X K were done on all patients. All but one patient had positive results, usually in the second week of the disease. The therapy for all these cases was entirely symptomatic and supportive. Aspirin, codeine and phenobarbital were given to allay the headache and pains and reduce the temperature. The seriously ill patients received plasma and blood transfusion. Because of the hypotension which practically all patients had, the possibility of adrenal insufficiency arose, and normal saline, 1 to 2 liters per day, was given intravenously as well as salt by mouth. There was no apparent result from this treatment. Five patients whose heart sounds were distant, "tick tack" in quality, and had edema of the feet and cyanosis, were given 50 cc. of 50 per cent glucose four times daily, and digitalis with some improvement in the general condition. Three of these patients ultimately died. Frequent catharsis and enemata were needed to insure adequate bowel movements. To stimulate appetite and help maintain nutrition, all patients received egg nogs with ½ oz, of whiskey twice daily. Ferrous sulfate was given to all cases. The eschar received simple cleansing and dry dressings. No attempt was made to use convalescent serum as this procedure was found to be of doubtful value by Australian workers. Penicillin was given to three cases with no beneficial effect. Sulfa drugs were not used on any patients. Three cases had positive malaria smears and all received adequate doses of quinine with no apparent effect on the temperature.

There were three deaths in our series of cases making a mortality of 14 per cent. However, three mild proven cases were treated at the island sick bay and if these are included, the corrected mortality is 12.5 per cent.

Post mortem examinations were done on two cases, both showing similar findings. There was pleural effusion bilaterally, pericardial fluid and ascites, all of moderate degree. The lungs showed patchy areas of consolidation, and in one case there was considerable hemorrhagic fluid on cut section. The heart was grossly normal in one case, but the other showed marked dilation of the right ventricle with a flabby muscular wall. On cut section the muscle looked much paler than normal. The spleen in one case was about 5 times normal size, covered with a fibrinous exudate and extremely friable, and in the manipulation of bringing it into view, it burst and a mushy splenic pulp oozed forth. The spleen in the second case was about 3 times normal size, moderately soft, but appeared normal on cut section. The liver in both cases was markedly enlarged, cut with slightly decreased resistance, and was paler than normal. The adrenal glands in one case appeared to be extremely soft and friable, but were grossly normal in the other. The kidneys were slightly enlarged, and in one case the cut surface revealed indistinct demarcation between cortex and medulla. Aside from scattered petechial hemorrhages on the walls of the lateral ventreiles, the brain and meninges appeared grossly normal.

SUMMARY

1. An outbreak of Scrub Typhus, consisting of 21 cases occurring on one small island in the South West Pacific, is described.

2. The symptoms, physical findings and laboratory data of the disease are described and the therapy discussed.

3. The mortality of this epidemic was 14 per cent.

4. The gross post mortem findings in two cases are described.

*Note*—We wish to give credit to Lt. Commander E. Bogen who did the Weil-Felix agglutination and to F. B. Luckett, PhMlc. and E. C. Greene, PhMlc. for doing the laboratory work.

# THE GRACE-NEW HAVEN COMMUNTY HOSPITAL

One of the important medical centers of this country is gradually taking shape in New Haven as committees and architects perfect their plans for the hospital consolidation known as the Grace-New Haven Community Hospital.

While the name of the new institution stresses community service its scope will obviously be far wider, combining as it will not only the two old established hospitals named but the facilities and skills represented by the Yale School of Medicine together with a complete new addition to the hospital of some 450 beds capacity containing all of the facilities associated with a modern institution.

Maintaining programs for the training of both physicians and nurses as well as for the care of more than 900 patients, the new institution will not only bring the ratio of hospital beds to population served more nearly in line with the growing demand for such service but will offer exceptional opportunities for the physicians of the state to keep abreast of rapidly changing techniques in medical science.

Administered under a single board of directors representing the boards of the two parent hospitals, Grace and New Haven, the new hospital will comprise both teaching and non teaching units.

Two medical boards will supervise professional care in the hospital, one representing the Yale School of Medicine in its affiliation on the teaching wards, the other representing the staff of Grace Hospital and the private staff of New Haven Hospital in the balance of the new institution including the new building.

The New Haven Dispensary will continue its service in affiliation with the new community hospital, adding greatly to the character and scope of service to be offered, while both the Grace School of Nursing for high school graduates and the Yale School of Nursing for college graduates will offer their advantages of training and service to the new combined institution.

In addition, the intern training program carried on by Grace Hospital will be continued in the new building where some 100 beds will be reserved for ward patients.

The new building, for whose construction a $5,000,000 building fund campaign has already been launched, will be erected adjacent to New Haven Hospital in the block bounded by York, South, Park and Oak Streets, and connected with the present New Haven Hospital plant by a tunnel.

Of strikingly modern lines, the new building will rise 12 stories from its front entrance on the hillside while sloping ground will give it an additional story at the rear for receiving facilities.

Douglas Orr, of New Haven, architect of the new building, has chosen a floor plan of modified X-shape providing four wings radiating from a central core. Patients, housed in the wings, will accordingly not only receive the maximum amount of light and air but will be spared the disturbance of traffic passing their doors, while elevators, food service, linen rooms and other utilities housed in the building's central core will be grouped for efficient operation.

The plan of the tenth floor, reproduced in this issue, shows a floor typical of patient accommodations. Elevators for patients, the public and service are grouped in the central core with divided lobbies for patients and visitors. The nursing stations are each located so that they overlook two wards, while there is a glass-enclosed solarium in the front of the building.

Utility and linen rooms are located at the junction of the wards while food service, consulting rooms and a nurses' rest room are found in the central part of the building.

Patient accommodations begin on the fifth floor and run to the top floor.

The ground floor, with its service entrance in the rear, contains many of the "back of the house" departments such as housekeeping, maintenance, supplies, linen room and record storage. Plans also include a large auditorium on this floor.

On the street floor, in addition to a commodious lobby and waiting room, are located the admitting and accounting departments, the accident room, physical therapy department, locker rooms for employees, staff suite and administrative offices.



The second floor contains the main kitchens and dining rooms as well as a snack bar and a medical staff dining room, while offices and classrooms for the nursing school and a library are also on this floor.

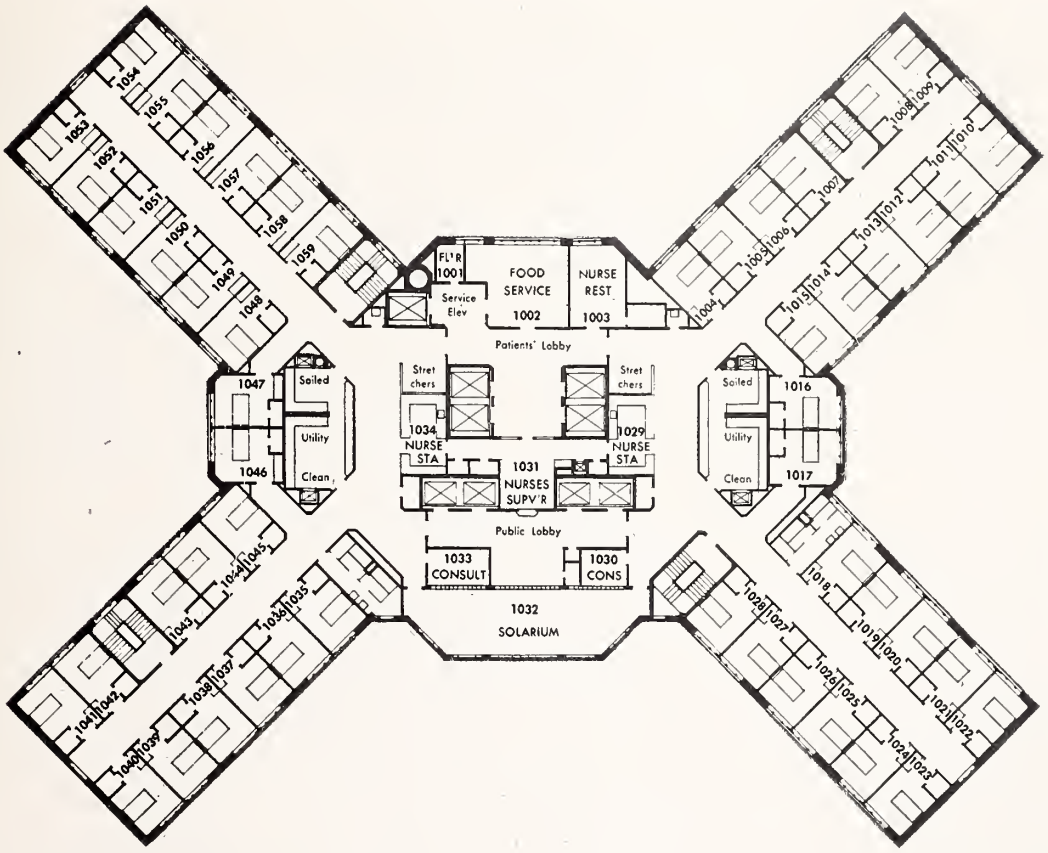
Roentgenology and clinical laboratories are located on the third floor, while the fourth contains the air-conditioned operating suites.

Need for additional hospital facilities in the New Haven area has been growing more and more apparent for some time. At the same time that Blue Cross has been developing an increasing demand for hospital space, New Haven's ratio of hospital beds per 1,000 of population has been well below the widely accepted standard of 4.5. The new hospital will effect a net increase of hospital beds in the community of 228, raising the number of beds in the community to 4.4 per 1,000.

Both New Haven and Grace Hospitals had for some time been considering separate measures to meet their needs for new building,—Grace to replace much of its aging plant, and New Haven to provide additional beds for private and semi-private patients. This summer, for example, the waiting list at New Haven Hospital has been running above 200, largely private patients.

The advantages of consolidation were agreed upon by the two hospitals early this winter, the necessary legislation was passed by the General Assembly, and land acquired for the building.

While no actual building can be done until the conclusion of the war with Japan, the campaign to raise the amount needed, $5,000,000, was launched on June 12 with a dinner at which several hundred of New Haven's leading citizens heard the Building




Fund's chairman, Thomas I. S. Boak, works manager of the Winchester Repeating Arms Company, describe the entire project while representatives of Medicine, the Church and the City endorsed the plan as being of great value to the community.

Under the slogan "United for Health," representatives of the Building Fund are calling on industrial leaders whence much of the Fund's support is expected. Opportunities for the creation of enduring memorials are being offered to those whose means will permit, and early next year the Building Fund's needs will be carried directly to the public.

Among the many committees who are working to bring the new hospital into being is a large and representative Doctors' Advisory Committee whose officers are as follows: Dr. Creighton Barker, Dr. Howard S. Colwell, Dr. Theodore S. Evans, Dr. Joseph I. Linde, Dr. Grover F. Powers and Dr. Thomas H. Russell.

Today more accurate diagnostic procedures, new techniques in surgery, chemotherapy and other fields are emerging more rapidly than ever before. Many are being developed at the battlefront. Increasingly their effectiveness in saving life is dependent on the coordinated facilities and equipment and the qualified, trained staff available only in a modern hospital. For example, as the sulfa drugs, penicillin and other new discoveries are more widely employed, the physician increasingly requires that they be administered in a completely equipped hospital where skilled laboratory technicians and extensive scientific apparatus make possible the tests which are considered necessary for effective treatment of the patient.

The expansion program of the Grace-New Haven Community Hospital conservatively anticipates post war growth in demands for service and the introduction of new scientific developments as swiftly as they prove their effectiveness in the fight against disease.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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SUBSCRIPTIONS: Membership in the Connecticut State Medical Society includes subscription to the JOURNAL. Additional copies may be secured from the Editor.

REPRINTS: Order blanks for reprints will be sent to each author with the galley proof of his manuscript. Reprint orders should be returned at once as the type will be destroyed within one month following publication of the manuscript.

# EDITORIALS

## Building Fund Progresses

The Trustees of the Building Fund report continuous progress in the growth of the Fund. Approximately 500 members have already contributed, new pledges are being received steadily and many hundreds more are confidently expected.

The total of the Fund has now assumed such size that the ultimate goal seems assured and the Board is directing its attention to the acquistion of a suitable site for the building.

The Advisory Committee on the site has been appointed in conference with the President of the New Haven County Medical Association. This Committee consists of Ralph W. Nichols; president of the New Haven County Medical Association, Eugene M. Blake; president of the New Haven Medical Association, Samuel J. Goldberg, Sr., William C. McGuire and Frederick N. Sperry. Two or three members of this Committee have had long experience with New Haven real estate and are unusually well informed on available and desirable locations and real estate values. Some of them also planned and carried out the purchase of the building for the New Haven Medical Association, its remodeling and financing. This Committee has already met in conference with the Board of Trustees and many sites and proposals were considered.

The possibility of acquiring an existing building to be remodeled for the Society has not been finally abandoned but there do not appear to be many possibilities of this kind so the Board and the Advisory Committee are especially concerned with a site for a new building.

After the location has been selected, the Board will proceed with plans for a building that will be adapted to the chosen site and suitable for the needs of the Society. It is becoming increasingly evident that the Society needs larger administrative and working quarters so that all of the many activities may be consolidated. A need particularly evident is a place to hold large committee meetings and conferences.

Members who have not already contributed to the Building Fund are urged to do so now. A little later a report of contributions by counties will be published showing the proportion of members in each county association that have made pledges and the total amount contributed in each county. If you have mislaid your pledge card another will be sent from the secretary's office on request.

## An Old Theme

The subject of medical economics is rapidly becoming an old theme and many of its variations are old and worn, but new combinations are ever with us and to these we must always give careful attention. It is true that, as a group, physicians have been but little exposed to the scholastic discipline of the social sciences and social organization, but it is equally true that no individual group has had greater experience with, and firsthand knowledge of, the practical aspects of the way people live and think. That physicians are able to evaluate their own place in the social structure with some degree of accuracy may be surmised in considering an unbroken written record, extending over twenty centuries, of the relationships of that position. While medicine has been subject to change due to environmental adaptation, the objectives have always endured, for they are eternal.

A recent writer has properly observed, "as for the 'either or' of private practice or socialized medicine, there is no such question. There are a myriad of schemes under which the doctor and patient may be brought together—not a choice between just two." This should not be forgotten in our effort to adapt sound principles to medical needs. In most of the discussions of plans which have been offered by the proponents of compulsory medical insurance the theoretical blueprints do not seem very much concerned with the eradication of economic conditions which are so closely associated with serious disease in the low wage earning group. No physician finds fault with proper plans for a better distribution of the facilities of modern medicine whereby all groups could be reached, but the methods suggested by some of the self-appointed planners is so contrary to time-tried and sound principles that ignorance must be blamed for their fanciful invention. One advocate of complete government controlled medicine stated that the trouble with physicians is that they are incurable individualists. This was offered as an indictment of this group of citizens whose record for generous and altruistic service to their fellow men is entirely without parallel. The reply might be made that, if the American physician is an incurable individualist, one reason for encouraging him to remain so is in order that he can continue to treat his patients on a personal and individual basis and not according to methods characteristic of the assembly line. The preservation of individual action means the preservation of individual thought and a kind of thinking that is not to be found in regimentation. One of the wise men of our generation, Dr. Harry Emerson Fosdick, in considering the present political situation makes this statement, ". . . we are being regimented and conscripted and dictated to in ways that would make our founding fathers turn over in their graves. That kind of thing is always involved in modern war. In war we find ourselves in a position where we want the government to do things for us that only the government can do, but then, when we have given the government the power to do things for us, we wake up to find the government has power to do things to us. So Thomas Jefferson once asked, 'What has destroyed liberty and the rights of man in every government which has ever existed under the sun?' And he answered, 'The generalizing and concentrating all cares and powers into one body'."

## Postgraduate Instruction

One effect upon medicine of certain social changes which have been accelerated by the war has been to make physicians realize a certain interdependence if they are to preserve their status as an entity in the social structure. The development of scientific medicine itself has created a similar consciousness for the complexities of medical practice today are such that the professional isolation characteristic of the previous generation is gone forever. In the field of medical education a similar evolution is taking place and the use of medical centers as places for teaching, not only for medical students but for medical practitioners, is becoming frequent. In this field, too, the war has stimulated our thinking and the question of refresher courses and postgraduate instruction for returning medical officers is a problem which should concern all those whose responsibilities include instruction in medical science, whether in schools, clinics, or hospitals. The educational need, not only for those returning physicians but for practicing physicians as well, was recently expressed in the *Detroit Medical News* by Dr. Frank

A. Weiser, who emphasizes the necessity of a postgraduate school geared to the level of the practicing physician. One plan for meeting this need is seen in the recent announcement of courses by the Wayne University College of Medicine during the quarter beginning July 2, 1945. These courses are given once each week with fees running from five to twenty dollars per course and embrace the subjects of bacteriology, internal medicine, physiology, surgery, and anatomy. In surveying the structure of these courses, it is obvious that those listed under internal medicine and surgery could be given in any hospital where suitable clinical material was available. Thus, under internal medicine we find diagnostic conference, therapeutic conference, hematology clinic and gastro-enterology. Under surgery is seen chest conference, x-ray conference, surgery conference.

In our own State the great success of the Clinical Congress as an institution of postgraduate instruction shows that further excursion into this field, especially for smaller groups, should be fruitful and is highly desirable. There are certain centers in Connecticut where clinical material is available for this use provided the instruction is organized and that those who take charge are willing to take a leaf from Mark Hopkins' book. This means that the undergraduate pedagogical viewpoint will have to be abandoned and that those taking such courses should be given responsibilities wherever possible other than those of being simply auditors. It would appear that opportunity is knocking at the doors of certain of our large hospitals, an opportunity which, if taken and explored, should develop into mutual benefits for all concerned.

## Increased Liability For Fatal Injuries

The action of the 1945 General Assembly in raising the limit for recovery of damages for injuries resulting in death to $20,000 is clearly a matter of interest to the medical profession because of its relation to professional liability protection. This limit, which is at present $15,000, has in all probability been the most important guiding factor for physicians in determining the amount of professional liability insurance which they should carry. With the revised statue taking effect on October 1, 1945, many will wish to give serious consideration to the advisability of purchasing increased protection to meet the increased liability.

The amended statute, Section 1430e of the 1939 supplement to the general statutes, will read as follows: "In any action surviving to or brought by an executor or administrator for injuries resulting in death, whether instantaneous or otherwise, such executor or administrator may recover from the party legally at fault for such injuries just damages not exceeding *twenty thousand dollars*, provided no action shall be brought to recover such damages but within one year from the neglect or fault complained of."

## The Revision of the By-Laws

In this issue of the JOURNAL the revised By-Laws of the Connecticut State Medical Society are published in full. The present revision was accomplished through the intensive and thorough work of the Committee on Revision of the By-Laws under the chairmanship of William M. Shepard and of a special committee from the Council headed by Arthur B. Landry.

The operation of the Society and the activities of its many committees are governed by these By-Laws and consequently they concern every member and should be a matter of knowledge to all. Some of the changes which have been made are editorial or technical in nature and do not materially alter present practices of the Society. Others are more far-reaching and those here abstracted merit particular attention.

The addition of Section 3 under Article V is already familiar to the majority of the members of this Society for the establishment of Student Membership was approved by the House of Delegates at its special meeting in December, 1944. Paragraph 4, however, should be noted, since it provides that student members shall become eligible for active membership in the several County Associations immediately upon licensure to practice medicine in Connecticut, without the waiting period of residence within the county. This provision is, of course, subject to such regulations as may be imposed by the County Associations.

A second change of importance is the designation, in Article VI, paragraph 1, of the vice-presidents of the Society as the First Vice-President and the Second Vice-President. This revision establishes the order of succession to the office of President and Section 2, paragraph 3 specifically states ". . . In the event of a vacancy in the office of President, that office shall be filled for the remainder of the unexpired term by the First Vice-President and he will be succeeded by the Second Vice-President."

Article VIII, Section 1, paragraph 1 concerns the membership of the House of Delegates and now

reads ". . . It shall consist of the delegates elected by the component county associations and *the members of the Council.*" In order to accomplish the inclusion of certain additional members of the Council, that is the delegates to the American Medical Association and the Editor of the JOURNAL, as members of the House of Delegates, it was necessary to secure the approval of the Legislature of a change in the charter of the Society. S84, the bill which was introduced in the 1945 Legislature to accomplish this purpose was passed and the By-Law is now altered to conform to the charter.

It will be observed that paragraph 6 under Article X, Section 3, Duties of Committees, now omits reference to the consideration of matters pertaining to the operation of the Workmen's Compensation Law as a function of the Industrial Health Committee.

Paragraph 11 in this same section is revised to bring about significant alteration in the composition of the Committee on Public Relations, which was previously nominated on a geographical basis. Under the new provisions, the Council is limited in selecting the members of this committee only in the total number which may not exceed eight.

Article XI, Section 3, Fidelity Bonds, charges the Council with the obligation to ". . . prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society."

The collection of dues is clarified by Article XIII, Section 10, paragraphs 1 and 2. Paragraph 1 provides that any of the component county associations may collect the annual dues assessed by the Society and if they elect to do so, shall forward monies so collected to the Treasurer at specified intervals. If the component county association does not choose to collect the annual Society dues, it is provided in paragraph 2 that the Treasurer of the Society shall collect the annual dues assessed by the Society and the dues assessed by the county association from the members of that association and shall remit periodically to the county association all monies collected on its behalf.

## Footprinting of the Newborn

In a recent issue of the F. B. I. Law Enforcement Bulletin the value of footprinting the newborn was emphasized as an effectual means of personal identification. For this purpose three factors must be present, individuality, continuity and immutability. The possibility of any two human beings having surface areas of skin in their fingers, palms or feet which have the same characteristics is so remote that it is beyond the realm of possibility. The definite formation of these ridges in these areas begins several months before birth and remains throughout the entire life in their original formation and cannot be changed. The advantage of footprinting over finger printing is that the ridges are more pronounced and the prints are easier to obtain in the newborn. The taking of footprints immediately after birth provides a permanent record of individuality so that in the event the question of identity should arise later conclusive proof can be offered. In Europe as a result of the war identity of children dislocated from parents has become a real problem and emphasizes the importance of such methods of identification. Even in peace times children may be lost or stolen whose identity may then become lost unless such records are available.

## Sterilizing National Income

The Congress is taking a practical and hard-boiled turn of mind toward Wagner-Murray-Dingell Bill. The bright sunshine of the never-never land of the social planners is being dimmed a little by the question if the way to this Utopia may be worse than what is being left behind.

Thought is now being given to how much Mr. Wagner's scheme is going to cost and what will happen to the billions of dollars that he wants collected in social security taxes. It is becoming increasingly evident that the greatest weakness of legislation of this kind is the fact that it would sterilize a considerable part of the national income, transfer it from active use in supplying consumer needs and increasing the volume and velocity of business transactions and would place untold billions each year in the general treasury, obstensibly to be used in building a reserve for the payment of claims but actually being treated as a part of the general revenue of the government.

Congress has resisted the application of the higher taxes on payrolls because of the unspoken fear of the effect which doubling the withdrawals from active use of such large amounts would have on our economy. Quite aside from any controversy that medicine may have there should be a thoughtful pause before the Federal Government takes this huge amount—it is twice as much as it cost the whole

government to operate twenty years ago—and puts it in a cold fund to be doled out to particular groups in particular ways through a tremendous welfare bureaucracy.

## The Hill-Burton Bill

The importance of a knowledge of the proposed national legislation concerning hospital construction cannot be over emphasized. If passed this bill will affect medical practice everywhere in this country and the part of the physician in the program is obviously a significant one. The statements made at the hearings on the bill which we present in part deserve careful reading for they are instructive and comprehensive. It should be pointed out however that since these hearings were held a new version of the Wagner-Murray-Dingell bill—S1050 has been introduced. This new sickness insurance bill has included for its first section much that is good and approved in the Hill-Burton bill but without the same liberal provision for administration and sound control.

## The Grace-New Haven Community Hospital

We are pleased to present in this issue a statement and plans concerning the relatively new Grace-New Haven Community Hospital project. While the plans for this enterprise represent an exceptionally extensive program of hospital development in one of our large urban centers it will be borne in mind that other important post war hospital developments in our State also are going forward. It is the hope of the editors that statements and plans of these latter projects will be forthcoming for publication and that our readers can be thus further informed of these significant developments in hospitalization.

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## Society Group Health and Accident Benefits Extended

The extension of the protection provided under the group health and accident insurance contracts written for members of the Society has been announced by the Commercial Casualty Insurance Company. The increased coverage, which will become effective September 1, 1945 and will apply to disabilities originating after that date, entails no additional cost to subscribers and broadens the benefits as follows:

1. The weekly accident indemnity, heretofore payable for a period of fifty-two weeks, is extended to provide payment for five years.

2. Sickness indemnity under the present policy begins with the eighth day of disability. Under the new arrangement, if hospitalization is required during the first week of disability, payment of sickness indemnity will date from the first day of hospital confinement.

Further extension of protection, without change in the premium, are planned by the insurance carrier, as the volume of business increases and the risks are spread. Members who are not now covered by the Society's group health and accident contract may obtain information concerning it from the Secretary's office.

## New Publications From State Department of Health

The Connecticut State Department of Health recently has published three pamphlets covering different phases of the work of its Bureau of Laboratories. *Stool and Urine Cultures for Enteric Disease Organisms* describe the method for examining stool and urine cultures. It is a slight modification of mimeographed sheets which the Bureau has distributed quite widely. The method was designed for use at approved laboratories throughout Connecticut but many demands have come for it from all over the country as well as from individuals outside the United States.

The other two publications are the *Report of the Sanitation Services of the Bureau of Laboratories for 1943* and the *Report of the Diagnostic Services of the Bureau of Laboratories for 1943*. The Bureau hopes to get these reports out more promptly in the future, thus making available this material to persons who are interested in it and who will make use of it.




THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# PRESIDENT HOWARD REPORTS ON THE ORGANIZATION OF A COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

On Wednesday, July 18, delegates from the six New England states met in Providence, R. I., to organize a Council of New England State Medical Societies. The following delegates were present:

New Hampshire: Richard Robinson, president, New Hampshire Medical Society.

Vermont: B. F. Cook, secretary, Vermont State Medical Society, and one other delegate.

Massachusetts: Michael A. Tighe, secretary, Massachusetts Medical Society, Dwight O'Hara, Allen G. Rice.

Connecticut: Joseph H. Howard, president, Connecticut State Medical Society, James R. Miller, chairman, Council.

Rhode Island: John F. Kenney, president, R. I. Medical Society, William P. Buffum, secretary, Herman C. Pitts, president-elect.

Due to transportation difficulties, the Maine delegates were unable to attend.

The purpose of the Council is contained in the preamble of this organization and is as follows: The main purpose of this Council is to bring about a closer coöperation between the State Medical Societies in New England in the development and maintenance of the highest standards in the conduct and administration of medical care, in the development of plans to improve the health of all the people in the New England states.

In as much as all the composing members have problems peculiarly their own that can not be solved by any general provision, this Council seeks to deal with those large matters in which all of the State Medical Societies are equally concerned. Further, this Council avows the principle that it shall not constrain its members to relinquish any existing affiliation, nor shall it seek to supersede the control now exercised by the governing bodies of each respective State Medical Society, nor by the House of Delegates of the American Medical Association.

The method of procedure as adopted at this first meeting specifies that the annual meeting shall be held on the third Wednesday, April of each year. That each Medical Society shall be entitled to three delegated representatives, but shall have only one vote. That a unanimous vote of the delegates is sufficient to pass the measure, but all Council decisions must be submitted to the governing bodies by the constituent members for approval unless such governing bodies officially empower their representatives on the Council to act with final authority.

The expenses of the Council shall be pro-rated annually among the State Medical Societies belonging to the Council. The members were requested to ask their representative Societies to donate $100.00 each to cover expenses until the first meeting of the Council.

The following matters will be considered for discussion during the next several months:

1. HOSPITALIZATION:

An attempt will be made to have uniform contracts, as far as possible for the New England States.

2. VOLUNTARY MEDICAL CARE INSURANCE:

An attempt to devise some plan which will be acceptable to all the States is desirable.

3. AID TO MEDICALLY INDIGENT:

At the present time, the medically indigent in several of these states is directly under control of the Welfare Department. A study of this problem and the desirability of placing these patients under the Health Department should be considered.

4. FEDERAL-STATE PROGRAMS:

Shall the State participate in this federal program and shall the State match funds of the federal government for medical care?

5. PUBLIC RELATIONS:

The importance of this has been emphasized previously and a plan for the New England States to participate in a wider program of education through the press and radio is to be considered. The desirability also of the Council joining the New England Council should be considered. The New England Council consists of about 1200 industrial, commercial and agricultural associations and this should be an opportunity for the medical profession to establish better relations with groups in these other fields, which should be of great advantage to our organization.

6. NATIONAL LEGISLATION:

The advantages of well organized opposition to national legislation detrimental to the practice of

medicine is apparent. Action will be taken by the Council on any type of legislation which interferes in any way with the present type of the practice of medicine.

Temporary officers elected were as follows:

President: Dr. James R. Miller, chairman of the Council, Connecticut State Medical Society.

Vice-President: Dr. John F. Kenney, president of the Rhode Island Medical Society.

Secretary-Treasurer: Mr. John E. Farrell, executive secretary of the Rhode Island Medical Society.

The next meeting of the Council will be held on October 14, 1945.

## GENERAL MOTORS ANALYZES IMPLICATIONS OF SOCIALIZED MEDICINE

### THE ECONOMIC BASIS OF HEALTH

Early in 1945 a very interesting analysis of various government surveys relating family income and medical care usage to sickness was presented by a member of General Motors staff to the Industrial Hygiene Foundation. This report is one of the by-products of the analysis of the union demand for paid sick leave before the War Labor Board. It was found that families of moderate income, i.e., families of four with incomes equivalent to $1,800 a year at present prices, without special assistance with their medical budgets, appear to achieve as good a health record as much more favorably situated families. The additional income above $1,800 which made possible increased expenditures for medical care did not result in better health. According to Andrew T. Court of the Labor Economics Section, General Motors Corporation, the implication is very strong that among these moderate income groups an economic basis for full health is provided by their normal earnings and the traditional practices of the medical profession. Although those in higher income brackets spent more for medical care, they did not actually receive a great deal more medical service. It was estimated that moderate income families would use over 50 per cent more medical care than do the higher income bracket families at present if all expenses were handled on a prepayment basis and physicians were reimbursed with a specified typical fee for each individual service, without any limitation on usage. This extreme increase in the demand for medical care probably would not improve the health of these moderate income persons. Also any economic change which reduces the cost of surgical operations to the individual does stimulate surgery without any evidence that better health has resulted. The probable medical care needs of very low income families, on the other hand, as reflected by their disability records, call for more medical care than they are actually receiving. Studying the Federal plan for sick leaves and the General Motors records in their Baltimore plants, it was found that sick leave with full pay will not tend to reduce the amount of serious illnesses, other things being equal. Mr. Court's study would seem to show that the medical profession has, in effect, already socialized its service without the necessity for any formal organization or external compulsion. Even the most complete studies are far from conclusive. Many more and better organized facts are necessary before undebatable conclusions can be reached.

### SICKNESS INDEMNIFICATION

W. M. Gafafer, chief of the statistical unit, Industrial Hygiene Division, Bureau of State Services, U. S. Public Health Service, discusses the mutual sick benefit associations and in particular their cash sickness benefit plan, the group health isurance plans, and one company non contributory plan. A study was made of the possible influence of various factors on claim frequency and on the number of paid days. Liberalizations in benefit plans were found to be a major cause of the increasing cost and amount of sickness with resulting higher rates. Claim rates yielded by a specific benefit plan depend primarily on what the administrators of the plan desire to accomplish. Dr. Gafafer believes that for the effective protection and improvement of the health of the worker, and incidentally for the determination of whether or not a benefit plan is accomplishing its objective, it is necessary (1) to record uniformly data on sickness of one day or longer, (2) to analyze the collected data carefully, and (3) to interpret the analyses with caution. Determining where, when, and under what conditions sickness is occurring is incontrovertibly a fundamental prerequisite for an effective program of preventive medicine in industry.

HEALTH INSURANCE PLANS

In his discussion of health insurance plans included in this analysis, Nathan Sinai, professor of public health at the University of Michigan, assures us that health insurance by its very nature is bound to grow. The element that made hospital insurance a hot line has forced the expansion of this protection to include surgery and obstetrics. This, he believes, is due to a consistent and dynamic public demand. He sets up four criteria by which any system or any application of the principle of health insurance may be judged: viz., the system must be medically sound, economically sound, socially sound, and administratively sound. Only in those instances where there is payment of the full bill in the form of either cash or service is there specific protection against a specified contingency. To provide, for example, a limited portion of hospital services or a specified cash payment per hospital day leaves the subscriber facing a great unknown. Not until the contingency is actually experienced does he have any idea of the percentage of protection that he has purchased. Dr. Sinai reminds us that it is a fallacy to assume that flat rates of payment to all hospitals in a community or to all hospitals and physicians in a state or across the country are the marks of sound administration. The expansion of hospital insurance together with surgical and obstetrical insurance into full hospital coverage, including professional care for surgical, obstetrical and medical cases runs counter to all the rules of reason. To quote Dr. Sinai: "It is my own opinion that Step III (full hospital coverage) is unworkable unless, at the same time diagnostic services, home and office services and home nursing care are included. Indeed, from the administrative and health standpoints it would be more logical and more productive to start with these latter services." The whole task of setting up health insurance calls for more than an administrator. It also calls for the training and skill of the actuary, the economist, the psychologist and the social anthropologist. Dr. Sinai's discussion brings up the basic query of how far a prepayment plan can be extended in scope of general medical care and be sound financially and medically without modification of the conventional fee for service method of compensating for medical and related services.

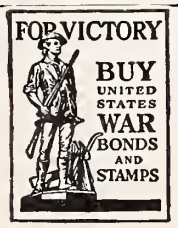
In a personal communication from F. G. Hughes, general manager of New Departure in Bristol, the writer states that "because the available evidence indicates that General Motors workers might receive no benefit from a program of socialized medicine, while they would materially contribute to its cost, it is in their interests to assist interested persons in understanding the true meaning of the government surveys which has not been previously disclosed in the official publicity."

## Ira V. Hiscock, Associate Member, Receives Legion of Merit

Colonel Ira V. Hiscock, recently released from the service and now back at Yale School of Medicine as Anna M. R. Lauder Professor of Public Health, was presented before his discharge with the Legion of Merit for his distinguished achievements. The citation, in part, reads as follows:

"For exceptionally meritorious conduct in the performance of outstanding services from April, 1943, to February, 1945. As Officer in Charge of the Public Health Section, Economics and Relief Branch of the Civil Affairs Division, Colonel Hiscock with rare foresight and ability supervised all matters relating to health services, hospitals, medical services and sanitation pertaining to the civilian populations in liberated or occupied countries, and acted as liaison between the Office of the Surgeon General, and Civil Affairs Schools, and the School of Military Government at Charlottesville, Virginia.

"His advice to the Civil Affairs Division on all medical matters within its jurisdiction and to the G-5 Division of the Theaters of Operation and tactical command headquarters, together with the prompt action taken by him, prevented the serious consequences which might have resulted from the dangers of disease to which our troops were exposed."




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(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## SPECIAL MEETING OF THE COUNCIL

A special meeting of the Council was held on Monday, July 16, 1945, at the offices of the Society, 258 Church Street, New Haven. There were present: the chairman, James R. Miller; Joseph H. Howard, Cole B. Gibson, Hugh B. Campbell, Thomas P. Murdock, Samuel F. Mullins, D. C. Y. Moore, Herbert Thoms, Charles T. LaMoure and Creighton Barker. Absent: George H. Gildersleeve, Floyd A. Weed, Harold E. Speight, Robert C. Paine and Stanley B. Weld. Also present from the Section on Radiology were Ralph T. Ogden, Berkley M. Parmelee and Hugh M. Wilson.

The meeting was called by the Chairman of the Council upon the request of representatives of the Section on Radiology of the Society for the following purposes.

#1. To discuss the request from the Section on Radiology that the Council defer further action on conducting a referendum on the subject of the inclusion of professional services in hospital service plan contracts that was voted by the House of Delegates at the annual meeting on May 23, 1945. The basis of this request on the part of the Section on Radiology is that such a referendum "might unfavorably prejudice the interest of members negotiating changes in their hospital-physician relations." The Section on Radiology further asks that the Council "maintain its sub-committee to continue further study on problems relating to inclusion of physicians' services in hospital service contracts and report its findings and recommendations to the mid-year meeting of the House of Delegates."

#2. To discuss and act upon the principles submitted by a committee from the Section on Radiology and considered without action by the Council on January 5, 1945.

### The Meeting

Purpose #2 stated above was first considered and it was voted that the Council approve, on behalf of the Society, the principles submitted by the committee from the Section on Radiology which are published herewith. It was further voted that the Secretary send copies of these principles to the President or Chairman of the Board of Directors of each hospital in Connecticut that maintains a radiological department setting forth in a covering letter that these principles have the approval of the Connecticut State Medical Society and urging that each hospital give them appropriate consideration as a guide in the revision of the operation of their radiological department.

The purposes in #1 above were next considered and it was voted that the sub-committee appointed to make the study of professional services in hospital service plans be continued and file its report with the Council in time for consideration by the Council at the regular monthly meeting in October, 1945, and that committee be privileged to recommend the postponement of the referendum authorized if, in the judgment of the committee, such postponement or omission is advisable.

It was voted that the Council reaffirm, on behalf of the Society, action taken by the House of Delegates at its semi-annual meeting on December 7, 1944, in which it was voted that the Society disapprove the inclusion of any professional services in contracts written by hospital service plans in the State of Connecticut and that the Secretary be directed to transmit the statement of this vote to the management of the Connecticut Hospital Service, Inc., and accompany that opinion with a copy of the principles covering radiological practice that have been approved by paragraph #1 of these minutes.

### Executive Session

Following the conclusion of these items of business the gentlemen from the Section on Radiology withdrew and the Council went into executive session.

1. Acting upon the request received from the Commissioner of the State Department of Health the Council recommended the appointing of an advisory committee to the Health Department to give counsel in the development of the program for psychiatric services in hospitals that was authorized by the 1945 General Assembly. The committee appointed consists of Harold A. Bancroft, Hartford; Arthur H. Jackson, Washington; Alfred Labensky, New London; Harry L. F. Locke, Hartford; Allan K. Poole, New Haven and William B. Terhune, New Canaan.

2. Nine student members were elected to membership in the Society.

3. It was voted that the Society enter a request with the Trustees of the American Medical Association to use its influence in formulating a clear and productive policy relative to the separation of medical officers from military service to return to civilian practice. The Chairman of the Council and the Secretary were directed to prepare such a statement and forward it to the Trustees of the American Medical Association on behalf of the Society and to the Directing Board of the Procurement and Assignment Service of the War Manpower Commission in Washington, D. C.

The meeting adjourned at 6:30 P. M.

## Resolutions from Section on Radiology

The Connecticut State Medical Society has unanimously affirmed that the inclusion of professional medical fees in Hospital Service Insurance contracts is unsound and detrimental to the best interests of medical practice, and that service benefits in Blue Cross Plans should be confined to hospital service. In order to facilitate a practical application of this action in radiological practice, the Radiological Section of the Connecticut State Medical Society recommends that the single x-ray charge now made to private and semi-private patients in hospitals should be separated into a hospital charge for technical service and a professional fee and believe that such a step would benefit the patient, the hospital and the radiologist by:

1. Preserving the private practice of radiology in the hospital regardless of whether the radiologist is full time in the hospital or has a private practice outside the hospital.

2. Placing the control of professional charges in the hands of the radiologists so that consideration can be given to individual circumstances.

3. Preventing the hospital and radiologist from exploiting one another.

4. Tending to reduce the cost of x-ray examinations.

5. Making the patient aware that a physician is being paid for interpreting his films.

6. Giving a clear understanding of how charges are computed and if charges are excessive, where that excess originates.

7. Placing the private practice of radiology in the hospital on a similar basis to that of other physicians.

## Principles Approved by the Council

1. That the practice of radiology is a part of the practice of medicine, and in hospital practice the radiologist should have the same status as chiefs of other services.

2. That when a single charge is made by a hospital to a private or semi-private patient for radiological service, it be recognized that a portion of that charge represents a fee for professional services and that it is desirable that the professional fee be separated from the charges for hospital service.

3. That hospitals should make a charge for technical radiological service based upon actual expenses plus a reasonable return on invested capital and for overhead and replacement, but that the Radiological Department should not be looked upon as a source of extraordinary profit to the hospital.

4. That control of professional radiological fees should be the jurisdiction of the radiologist and that a separate charge for radiotherapy, consultation, interpretation of films, and supervision of technical service should be billed and collected from the patient.

It is essential, as at present, that all x-ray examinations in hospitals have the status of a consultation and a written report made by a qualified radiologist. The hospital charge must be limited to a mutually agreed upon schedule of rates. The professional fee likewise must be based upon a submitted schedule of rates and if the intended purpose is attained, the sum of the two rates should be less, and in any event no greater, than the single x-ray fee now in general use throughout the State.

Although it is realized as traditonal, that the physician should bill and collect from the patient for his services, this method may not always be practical in connection with fees of radiologists serving in hosiptals and may be confusing to the patient. It is believed, however, that if fees for professional services be clearly separated from charges for hospital services on bills rendered by

hospitals, the desired objective would be accomplished.

## The Committee on Postwar Education for Veterans

An advisory committee on education has been appointed to aid the Service Bureau for Returned Medical Officers. The committee consists of: Francis G. Blake, Dean of the Yale School of Medicine; Lt. Col. James C. Fox, MC-AUS; Samuel C. Harvey, W. H. Carmalt Professor of Surgery at the Yale School of Medicine; Louis P. Hastings, Pathologist at St. Francis Hospital in Hartford; Herbert Thoms, Associate Professor of Obstetrics and Gynecology at the Yale School of Medicine and Creighton Barker.

## Board of Trustees of the Building Fund

The Board of Trustees of the Building Fund met with the special committee from the New Haven County Medical Association on July 11th for the purpose of discussing available and desirable sites and building zone regulations in New Haven. There were present from the Board of Trustees: James D. Gold, George M. Smith, and Daniel C. Patterson. Absent: C. Charles Burlingame, and Roy L. Leak. Representatives of the Council present were Joseph H. Howard and Creighton Barker. Absent: Stanley B. Weld. Present from the special committee were the chairman, Ralph W. Nichols; Eugene M. Blake, William C. McGuire and Frederick N. Sperry. Absent: Samuel J. Goldberg, Sr. Property proposed by the advisory committee was inspected by the Board of Trustees and much pertinent discussion was entered into.. Other conferences will be held in the future.

## Laboratory Evaluation Committee

The advisory committee to the Health Department on the evaluation study of serological laboratories met at the offices of the Society on Friday, July 13. The final report of the second evaluation study was presented and plans for future laboratory evaluation studies were made.

## Correction

The members of the special committee on the study of the Workmen's Compensation Law are: Lawrence W. Ward, Niantic, chairman; Andrew J. Jackson of Waterbury, James D. McGaughey of Wallingford, James L. Vickers of Greenwich and Karl T. Phillips of Putnam and not as announced in the July JOURNAL.

## Student Members Elected July 16

*Fairfield County*

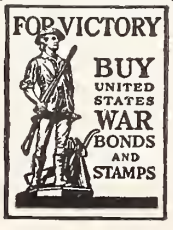
| NAME | FATHER'S NAME | MEDICAL COLLEGE | TOWN |
|---|---|---|---|
| Gabriel, Anthony R. | (John Gabriel) | Boston U. | Bridgeport |
| Reiner, Elliot R. | (Herbert Reiner) | Yale | Springdale |
| (now an intern at St. Elizabeth's Hospital, Washington, D. C.) | | | |

*Litchfield County*

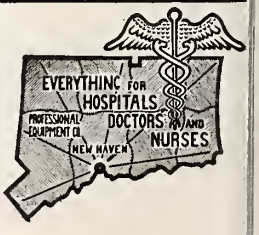
| | | | |
|---|---|---|---|
| Breakell, Edward S. | (E. L. Breakell) | U. Buffalo | Goshen |
| Lyons, William B. | (W. H. Lyons) | Georgetown | Thomaston |

*New Haven County*

| | | | |
|---|---|---|---|
| Colwell, Bradford S. | (H. S. Colwell) | Yale | New Haven |
| Judd, Charles S., Jr. | (C. S. Judd) | Yale | New Haven |
| Kussner, Shirley F. | (Joseph Kussner) | N. Y. Med. | Milford |
| Newton, Robert F. | (F. I. Newton) | Yale | New Haven |
| Segnalla, Ernest, Jr. | (Ernest Segnalla) | Marquette | New Haven |




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(SEE PAGE 2)

# MEDICINE AND THE WAR

## Major Craighill Reports On Health of Servicewomen Overseas

Major Margaret D. Craighill, Army Medical Corps, has made some instructive observations regarding overseas military duty for women, following her return to the United States from a 56,000 mile tour of war zones. Major Craighill, who is a member of the Connecticut State Medical Society, is another of its "firsts" since she was the first woman to be commissioned in the Army Medical Corps.

Major Craighill, in her special study of the health and living conditions of Army nurses and members of the Women's Army Corps, found that medical records supported her opinion that women over thirty-five, except those slated for top administrative posts, should not be sent overseas and that women in the forces should not remain overseas longer than two years. "The younger women are more flexible and better able to adapt themselves to the hardships and inconveniences they inevitably find," Major Craighill said. The present age limit for overseas duty of enlisted WACS is thirty-nine, while Army nurses are commissioned up to the age of forty-five

The health of service women overseas is, in general, excellent, Major Craighill was at pains to point out, and has far exceeded expectations. She attributes the fact that in many places they have done better than the men to better protection and housing and provide ample hospitalization even for minor ailments. Major Craighill also emphasized that the stories of the effects of tropical diseases on women's health are much exaggerated and stated that she wanted to talk down the seriousness of these, in particular the skin diseases.

Major Craighill graduated from the University of Wisconsin and from the Medical School of Johns Hopkins University. She served as an intern and resident in obstetrics and gynecology at the Johns Hopkins Hospital and as assistant in pathology in the Yale University School of Medicine. In 1928 she settled in practice in Greenwich where she remained until 1940 when she became the dean of the Women's Medical College of Pennsylvania. Dr. Craighill was commissioned a Major in the Medical Corps of the Army of the United States in May, 1943. Her recent tour for the Army Surgeon General's office took her to England, France, Italy, Egypt, Africa, the Persian Gulf, India, Burma, China, Ceylon, Australia, New Guinea, the Philippine Islands, Guam and Hawaii.

## Former Hartford Hospital Intern Awarded Bronze Medal

Captain Ludwig J. Pyrtek, who completed his internship at the Hartford Hospital in 1943 and as a member of General Patton's Third Army crossed France, Belgium, Luxembourg, Holland and Germany, has been awarded the Bronze Star Medal "for meritorious service in connection with military operations against an enemy of the United States from July 11, 1944 to April 24, 1945."

The citation continued: "Captain Pyrtek, as medical officer in a Clearing Company for an infantry division and later in a Collecting Company for an infantry regiment, during this period, has displayed extraordinary ability, tireless energy, understanding sympathy, and deep devotion to duty. Handling the patients coming under his care with a superior degree of professional skill, he has been responsible for the saving of many lives. His constant consideration of the welfare and comfort of the wounded and the efficient and unselfish manner in which he has contributed to the sucessful operation of these two organizations reflect credit upon his character and ability as an officer, and upon the Medical Corps of the Army."

Joe Pyrtek graduated from Hartford Public High School in 1935 and four years later from Dartmouth College. While in college he was an outstanding football and basketball player. Entering Dartmouth Medical School, he completed his requirements for his M.D. degree at Rush Medical College in 1942. From last reports Captain Pyrtek was stationed near Cologne, Germany. Since going overseas in May 1944 he has been awarded five battle stars.

## Information Bulletin for Medical Officers

The Bureau of Information of the American Medical Association has prepared and published a bulletin of 16 pages which contains information

of interest to medical officers of the Armed Forces. The first 4 pages are devoted to an explanation of the G.I. Bill of Rights, particularly as it interests physicians with its educational provisions and the opportunities for obtaining loans for the purchase or construction of homes, farms, and business property.

The present educational facilities in civilian institutions are outlined with detailed information supplied regarding review and refresher courses, internships, and residencies in the specialties. A table is included listing the reciprocity and endorsement policies of the 48 states, District of Columbia, and possessions. Various aids are recounted to assist the returned physician in establishing a practice. Finally, there is a list of the officers of the various state medical examining boards, a list of the approved examining boards in the specialties with their officers, and a bibliography of material recently appearing in the *Journal of the American Medical Association* of peculiar interest to veteran medical officers.

Copies of this Information Bulletin may be obtained directly from the A. M. A. or by writing the CONNECTICUT STATE MEDICAL JOURNAL.

## Promotions — Changes of Station

George I. Sneidman of Hartford has been promoted to colonel as commander of an Army hospital in the Pacific. A graduate of the University of Connecticut, where he was active in athletics, and the Medical College of Virginia, Richmond, Va., Colonel Sneidman was a member of the staff of Mount Sinai Hospital. Entering the Army more than four years ago with the commission of captain, he has been overseas about a year and a half.

Major to Lieutenant Colonel: William Bernard Koufman, MC, New Haven.

Major W. Holbrook Lowell, Jr., (Hartford) has recently been transferred from Randolph Field, Texas, to Westover Field, Massachusetts.

Lieut. Justin L. Cashman, USNR, (North Haven) is now with the U. S. Naval Auxiliary Air Facility at Westerly, Rhode Island.

## Public Health Service Officers Given Military Status

Twenty-six members of the Connecticut State Medical Society and ten other physicians from the state have been given full military status by an executive order of President Truman which has declared the commissioned personnel of the United States Public Health Service to be members of the military forces for the duration of the war. The entire commissioned corps of the Public Health Service, comprising about 3,000 physicians, dentists, sanitary engineers, pharmacists, other scientists and nurses is affected by this order which gives this personnel the same status, benefits, discipline and obligations as members of the other branches of the military establishment. The Public Health Service has no enlisted personnel.

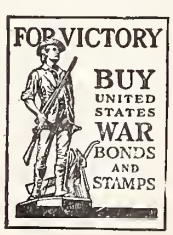
The administration of the Public Health Service has not been transferred to the Army or Navy and it will continue to operate as a part of the Federal Security Agency. The majority of the medical officers in the Public Health Service are detailed to the Coast Guard to which the Public Health Service furnishes medical care.

## Rochester, N. Y., Hospital Drops Anesthesia from Blue Cross

The Rochester General Hospital, Rochester, New York, recently announced that it would no longer include anesthesiology in the services furnished Blue Cross subscribers. Subscribers must pay $5 to $10 extra for anesthetics, said the hospital, "because payments from the hospital service plan have not been sufficient to meet the rising cost of hospital services and supplies."

## AMERICAN CONGRESS PHYSICAL MEDICINE CANCELLED

The annual scientific and clinical session for 1945 of the American Congress of Physical Medicine has been cancelled. This meeting was to have been held in New York City, September 5 to 8, 1945.




MAKING A MOUNTAIN OUT OF A MOLE — is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
*Fairfield County*, Berkley M. Parmelee, *Chairman*, Bridgeport
*Hartford County*, Louis P. Hastings, Hartford
*Litchfield County*, Sanford H. Wadhams, Torrington
*Middlesex County*, Harry S. Frank, Middletown
*New Haven County*, Charles T. Flynn, New Haven
*New London County*, Edmund L. Douglass, Groton
*Tolland County*, Donald Beckwith, Rockville
*Windham County*, Andrew O. Laakso, Danielson



# PUBLIC AFFAIRS

## News From Washington

Fears of the doctors in service that they will be ordered and held on duty with the Veterans Administration long after the war apparently may be allayed. Vigorous protest against the assignment of medical officers to the Veterans Bureau except on a voluntary basis was made by the Committee on Post War Medical Service to the Secretaries of War and Navy some time ago. This action was stimulated by the Executive Committee of the Board of Trustees.

Available information indicates that hearings on the Wagner-Murray-Dingell Bill will not be held for some time. The 1945 edition of the Wagner Bill is twice as long as the 1943 volume. In legislative parlence, "The thicker the bill the slimmer the chance of its passage." Here are three Wagner Bill indications:

1. This will not be rushed through Congress.

2. Plenty of time for analysis and study by local medical groups—Senator Wagner has invited this, himself.

3. To date press comment generally has not been over enthusiastic for bill—in fact most of it including some of the labor press being critical.

Although the Surgeon General of the Public Health Service apparently is given wide powers by the measure, in the final analysis the power of the purse rests directly in the hands of the Social Security Board, and it is well known that whoever has the say in regard to expenditures usually has the most definite say in regard to policies.

More and more medical officers are becoming concerned over the feeling that the Army Medical Corps has numbers of doctors who could be relieved to return to civil prcatice. Figures as to how many could be let of service starting within a few months vary from 15,000 down to 2,000. Without benefit of slide rules, punch cards or horoscopes, the following figure might be something to shoot at: Suppose that 1,800,000 men are to be let out of the Army now that V-E day has come, a conservative estimate is that there are five medical officers to every thousand men in service and, if that is true then 9,000 doctors could be let out of service on that basis. At least a definite statement as to why this could not be done would be most interesting.

Proposals for a Department of Public Health with a physician of Cabinet status have been renewed since the strengthening of the power of Cabinet officers has been moved up a pace by President Truman. These proposals are as yet unpublished but the format of one especially interesting plan is said to provide for a Secretary of National Health under whom would be the Surgeons General of the Army, Navy, Air Force, United States Public Health Service and Veterans Administration.

Architects are busily planning blue prints for so called health centers, rehabilitation centers, etc. Some definite proposals along this line will undoubtedly be announced soon.

## New Program for American Medical Association

The Board of Trustees and the Council of Medical Service and Public Relations of the American Medical Association have announced the adoption of a new fourteen point program for extending to all people in all communities the best possible medical care. The program's objectives include improved housing, nutrition and sanitation, all fundamental to good health, a medical survey in each community, an extended disease prevention program and an increased health insurance "on a voluntary basis."

### OBJECTIVES OF PROGRAM

The program's objectives were given as follows:

"1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation which are fundamental to good health; we support progressive action toward achieving these objectives.

"2. An extended program of disease prevention

with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

"3. Increased hospitalization insurance on a voluntary basis.

"4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

"5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

"6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

"7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

"8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

"9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

"10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

"11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural ares.

"12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

"13. Adoption of Federal legislation to provide for adjustments in draft regulations which will permit students to prepare for and continue the study of medicine.

"14. Study of post war medical personnel requirements with special reference to the needs of the veterans' hospitals, the Regular Army, Navy and United States Public Health Service."

# CORRESPONDENCE

## War Finance Division
## Treasury Department

Washington 25
July 6, 1945

To the Editor:

Our gratitude seems small-fry!

It's inadequate for the generosity, for the patriotism, for the effectiveness of publishers' cooperation during the 7th War Loan.

In our Washington offices, you can see for yourself the colorful and ingenious War Bond covers that are displayed, not by tens or scores or hundreds, but by the thousands: covering walls from floor to ceiling.

*And that's not all*—editorials, full-page ads, cartoons, and feature articles are all massed together in a demonstration of forceful influence unmatched in any previous campaign, public or private.

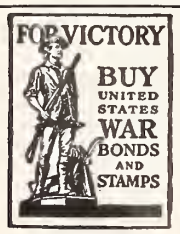
That's why our simple words of appreciation for your vital war effort support don't measure up to the Treasury's pleasant wish—to tell you how grateful we are. But your magnificent war financing contribution has other rewards: it's a helping hand for the care of our wounded, a strong blow to down any threat of inflation, a kind friend to fulfill hopes for education, homes, security.

Cordially yours,
Elihu E. Harris,
Chief, Periodicals Section

# THE DOCTOR'S OFFICE

Samuel A. Rose has returned from service in the Army of the United States and is resuming his practice at 65 South Street, Stamford. Practice limited to internal medicine.

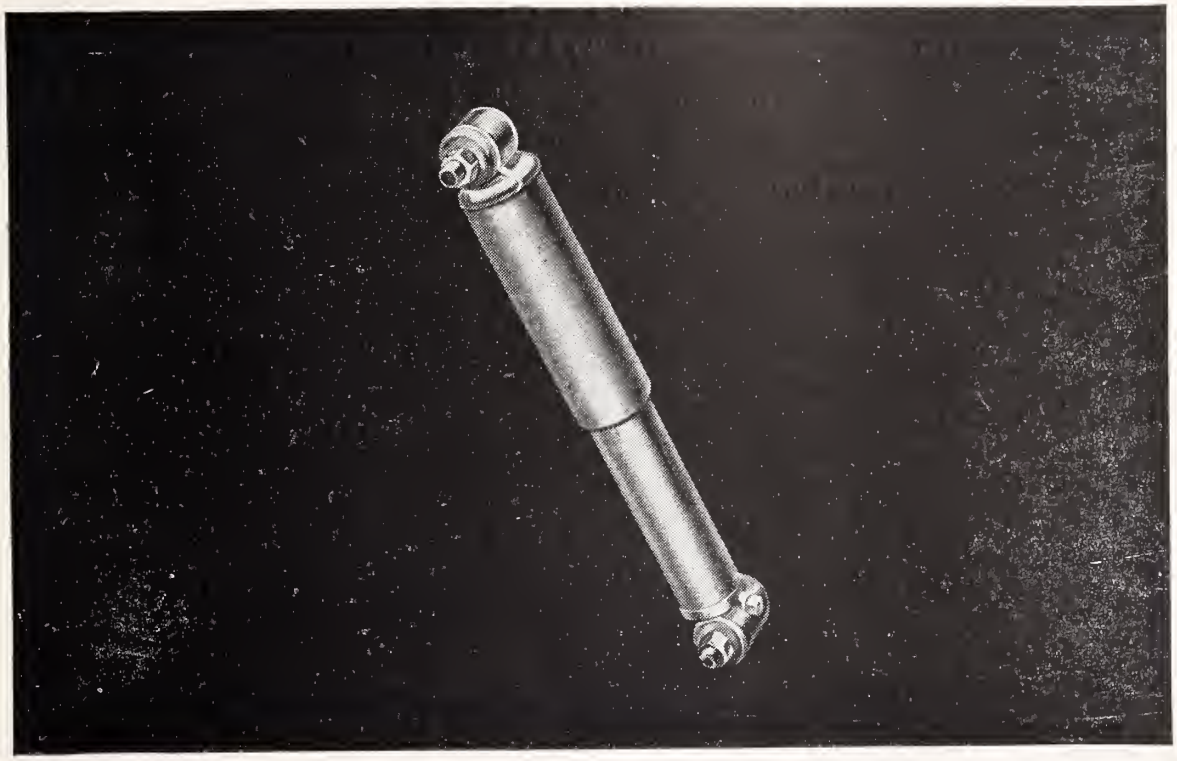
John Henry Grossman, formerly a member of the resident staff of The New Haven Hospital, has opened his office in Bridgeport.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)



# How many of these do you own?

**If you look** under your car, you'll probably find a couple of gadgets something like this one.

They're shock absorbers.

They take the sting out of sudden bumps and jolts. They make a rough road smoother.

**And if you're wise,** somewhere in your desk, or bureau drawer, or safe deposit box, you have a lot *more* shock absorbers. Paper ones. War Bonds.

If, in the days to come, bad luck strikes at you through illness, accident, or loss of job, your War Bonds can soften the blow.

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**Buy all the War Bonds** you can. Hang on to them. Because it's such good sense, and because there's a bitter, bloody, deadly war still on.

**BUY ALL THE BONDS YOU CAN...**
**KEEP ALL THE BONDS YOU BUY**

# WOMAN'S AUXILIARY

## TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. James Raglan Miller, *Hartford*
*President-Elect*, Mrs. James Douglas Gold, *Bridgeport*
*First Vice-President*, Mrs. Creighton Barker, New Haven
*Second Vice-President*, Mrs. H. Bertram Lambert, *Southport*
*Recording Secretary*, Mrs. Charles W. Goff, West Hartford
*Corresponding Secretary*, Mrs. Edwin R. Conners, *Bridgeport*
*Treasurer*, Mrs. Julian G. Ely, Lyme

## Board of Directors Meeting

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society met on June 11 at 11:30 A. M. at the home of the president, Mrs. James R. Miller, 181 North Beacon Street, Hartford. Reports from the officers, county presidents and committees were heard. A buffet luncheon was served at noon after which the business meeting continued and work for the coming year was discussed.

### BOARD OF DIRECTORS 1945-1946

OFFICERS

President—Mrs. James R. Miller, Hartford
President-elect—Mrs. James Douglas Gold, Bridgeport
First Vice-President—Mrs. Creighton Barker, New Haven
Second Vice-President—Mrs. H. Bertram Lambert, Southport
Recording Secretary—Mrs. Charles W. Goff, West Hartford
Corresponding Secretary—Mrs. Edwin R. Connors, Bridgeport
Treasurer—Mrs. Julian G. Ely, Lyme

COUNTY PRESIDENTS

Fairfield County—Mrs. James Douglas Gold, Bridgeport
Hartford County—Mrs. Arthur B. Landry, Hartford
Litchfield County—Mrs. W. Bradford Walker, Cornwall
Middlesex County—Mrs. Walter N. Nelson, Cromwell
New Haven County—Mrs. Luther K. Musselman, New Haven
New London County—Mrs. Alfred Labensky, New London
Tolland County—Mrs. Ralph B. Thayer, Somers (temporary chairman)
Windham County—Mrs. Ralph L. Gilman, Storrs

STANDING COMMITTEE CHAIRMEN

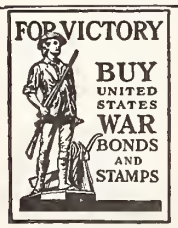
Finance—Mrs. Hugh Campbell, Norwich
Hygeia—Mrs. Dewey Katz, Hartford
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Organization—Mrs. Creighton Barker, New Haven
Parliamentarian—Mrs. Frederick W. Wersebe, Washington
Program—Mrs. H. Bertram Lambert, Southport
Publicity—Mrs. Ralph T. Ogden, West Hartford
Revision—Mrs. Paul S. Phelps, Canton
War Participation—Mrs. Frank S. Jones, West Hartford

## The News Letter

In May a printed news letter was mailed by the Woman's Auxiliary to Connecticut physicians in service. 500 letters were sent to men overseas and in this country. Approximately 50 were not sent because of incorrect addresses or no address at all. Because of fast moving events during May and June many letters did not reach their destination, although the postal authorities did their best to forward them. These letters have been returned for correct addresses.

During August the War Participation Committee will attempt to get in touch with families of physicians in service in order to obtain information as to change of station or of rank. The coöperation of friends as well as families will greatly facilitate the huge task of keeping the files up to minute.

*A postcard to the* Journal *office or to the War Participation Committee will help to get Connecticut news to far away installations where it is so much appreciated.*




**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)




# how well nourished?

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Actually, how well nourished *is* the diabetic or hypertensive or peptic ulcer patient? Only careful evaluation will determine whether nutritive failure exists as a result of his special diet.

According to Spies[1], "severe atypical deficiency disease, like other forms of nutritive failure, can be successfully corrected by the application of... four essentials." One of these is administration of the four critical water soluble vitamins *in high dosage.*

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*For complete information, write on your prescription blank "Nutritive Therapy", and mail to Squibb Professional Service Dept., 745 Fifth Avenue, New York 22, N. Y.*

Basic Formula SQUIBB

1. Spies, Tom D.; Cogswell, Robert C., and Vilter, Carl: J.A.M.A. (Nov. 18) 1944. Spies, Tom D.: Med. Clin. N. Am. 27:273, 1943. 2. Spies, Tom D.: J.A.M.A. 122:911 (July 31) 1943. 3. Jolliffe, Norman, and Smith, James J.: Med. Clin. N. Am. 27:567 (March) 1943.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

# OUR NEIGHBORS

## Maine

The House of Delegates of the Maine Medical Association met at Augusta on June 24 and elected Adam P. Leighton of Portland, president, John Piper of Waterville, president-elect, and Frederick Carter of Augusta, secretary. President Leighton has appointed a committee which is working wholeheartedly for the establishment of a medical school in that State. The land is available and the plans have been drawn up for a Class "A" Medical School. All that is lacking now are the funds.

## New York

Several secretarial telephone services in the County of New York are offering a three months' period of service without charge to physicians returning from the Armed Forces. This is to assist these physicians with their inevitable problems of readjustment attendant upon their return to the private practice of medicine.

Louis H. Pink, president of Associated Hospital Service of New York and former superintendent of insurance of the State of New York is en route to Manila where he will serve temporarily as special advisor to the Philippine Government in the reorganization of the insurance industry of the Islands.

## Rhode Island

Senator Green of Rhode Island on June 25 introduced a bill (S. 1188) into Congress to amend and extend the Social Security Act. Of particular interest is the amendment providing insurance for hospital care. An amount equal to one per cent of the payroll is to be set aside for hospital care, either directly or through some of the private organizations already in the field. It also includes a proposal for the Federal Government to match state payments to persons temporarily unable to work, similar to Rhode Island's plan of sickness insurance. In a statement to the Senate, Senator Green said he had limited his proposal to those modifications and additions to the Social Security Act on which he believed there may be fairly ready agreement. There are some who think this bill of Senator Green's might be adopted by Congress and, for this reason, it demands immediate attention.

# News from Yale University School of Medicine

The Yale Medical Society was honored with an address on July 11 by Sir Alexander Fleming of London, discoverer of penicillin and recent recipient of a Nobel Prize. Sir Alexander spoke to a large and enthusiastic audience on the subject of "The Development of Penicillin."

The accelerated curiculum of the Yale University School of Medicine is being modified to the extent that first year classes will henceforth begin in September of each year, rather than every nine months. However, following admission students will continue to progress in the accelerated fashion of nine month years to complete their schooling in three years.

# NEW BOOKS IN REVIEW

*A TEXTBOOK OF PATHOLOGY. By Robert Allan Moore,* Edward Mallinckrodt Professor of Pathology, Washington University School of Medicine, St. Louis. *Philadelphia and London: W. B. Saunders Company.* 1944. 1338 pp. 513 illustrations. $10.00.

Reviewed by Robert G. Grenell

It is always highly desirable and markedly stimulating to have published a new presentation of material in a field which is overwhelmed by tradition. This new text of pathology definitely falls within the small number of books in this category.

The first innovation is met with in the division of the subject matter. The two sections of general and special pathology usually found in pathology textbooks are here, but are separated, or joined—depending on the point of view—by a discussion of various disease conditions based on their etiology, i.e., diseases caused by living agents, by physical agents, by chemical agents, by deficiencies, and by conditions related to pregnancy and the fetal and new born states. Diseases of unknown or obscure cause are discussed by systems in the last section of the book.

It is exceedingly interesting that the section on general pathology, although relatively short (207 pages), deals with degenerative changes in a new and very stimulating manner. Admittedly, the discussions of inflammation and tumors are nearer the standard, but the retrogressive changes are presented not from the usual relatively anatomic point of view, but as disturbances in the metabolism of proteins, carbohydrates, lipids and minerals and body fluids. This correlation of histopathology with chemistry and psysiology

# MAGGI'S BOUILLON CUBES




## ...for a quick, delicious broth

There's nothing more appealing to convalescent appetites than a piping hot cup of Maggi's Bouillon—as a stimulating prelude to any meal.

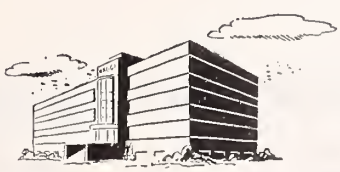
Made from the purest ingredients, scientifically blended to a time-honored Swiss formula, Maggi's Bouillon has a rich, full-bodied flavor that equals the finest home-made broth.

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- Two natural laxative ingredients (concentrated prune juice and pure mineral oil) blended into a mild, safe and effective aid to the correction of constipation.
- No harsh irritants . . . Just prunes and mineral oil, thus, PRUNAMIN can be recommended safely for young and old. No oily taste . . . only the flavor of rich Santa Clara prunes.




- PRUNAMIN was developed by Stoddard Brothers* at the suggestion of a group of physicians and now, after months of careful testing we submit this product for your consideration.
- We would be pleased to send samples upon request. Simply take one of your prescription blanks and mark on it, "PRUNAMIN PLEASE" and mail it to us today.

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is extremely valuable for the student (as well as the practitioner), and serves for academic pathology a similar function to that of the well known shot in the arm. It is to be hoped that Dr. Moore's "bank" of intellectual plasma infusions has not been exhausted and will be extended even further in later editions.

There are some who will undoubtedly carp at that part of the organization of the book's material which of necessity has scattered discussions of diseases of particular organs, or has made somewhat arbitrary the classification of diseases caused by living agents according to portal of entry, source of infection, class of organisms or method of transmission. However, students at this level can and should be expected to understand the use of an admirable index which in great measure compensates for the disadvantages of such classification. The book, being comprehensive, is necessarily large, but remains readable and up to date throughout. In fact, it is such a successful attempt to bring a new presentation to light, that the following few criticisms are offered by this reviewer as suggestions for a future edition rather than as petulant or school-marmish efforts to be picayune.

It is rather surprising in a book of this nature to find an almost complete disregard of the reticulo-endothelial system as such. To be sure, it is mentioned, but there is no discussion of its functions and significance, and certainly nothing to impress upon the student its over-all importance to, or its role in pathology of the organism. At least a reference might have been made to the excellent discussion in Downey's *Handbook of Hematology* (which itself appears nowhere in the admirable bibliography the book already possesses).

The author also seems to think it unimportant to interest the student in the techniques of clinical pathology and the methods and ideas of experimental pathology. (It is to be regretted that there is no comment on Speransky's *Basis for a Theory of Medicine*). One looks in vain for some mention of experimental method or for even a brief description of the biopsy or the currettage. Further, this reviewer submits that in as much as Dr. Moore is writing too instill new life into the pathology text, it would not be amiss to append some information relative to the postmortem. There is no reason why students should not be exposed to such a discussion as early as possible in their medical curriculum.

In a later edition it is suggested further that the length of discussion allotted to various topics could be proportioned to greater advantage (certain phases of the description of edema could be extended, etc.). The illustrations are good, in general, with but a few exceptions, and the bibliography is especially noteworthy.

On the whole, both the author and the publisher are to be commended for their highly successful volume, especially in this period during which so many obstacles must have beset their path.

*SURGERY OF THE HAND. By Sterling Bunnell,* M.D., Honorary Member of American Academy of Orthopedic Surgeons, Member of American Association of Plastic Surgeons and of American Society of Plastic and Reconstructive Surgery, Licentiate of American Board of General Surgery and Plastic Surgery. *Philadelphia: J. B. Lippincott Company.* 1944. 734 pp. 597 illustrations. $12.00.

Reviewed by Allan J. Ryan

The primary purpose of this book is to lay down a set of principles for the reconstruction of damaged hands. Almost four hundred of its over seven hundred pages are directly concerned with this problem and the remainder are designed to be supplementary to them. No attempt has been made to treat every subject exhaustively. Rather the emphasis is on conciseness, easy reading and liberal use of illustrations and diagrams. The book should be of interest to every surgeon and indispensable to those concerned with orthopedic and reconstructive work.

Dr. Bunnell's finest contributions to surgical technique have been in the field of tendon repair and reconstruction. This is reflected in the excellent sections of his book on this subject. Although the use of a stainless steel wire suture which can be pulled out when healing has occurred may not be unique in his hands, he has apparently developed it to a fine point. He will find some disagreement about his practice of immobilizing tendons up to three weeks after operation. He says, "At this stage, the tendons not exercised

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Constipation, and poor sphincter muscle control resulting from the use of cathartics, often yield to treatment by mechanically stretching the sphincter muscles. Sold on prescription only; not advertised to the laity. Obtainable from your surgical supply house or ethical drug stores. Set of 4 graduated sizes, adult $3.75. In Pediatrics, children's size, set of four, $4.50. Write for Brochure.
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Manhattan *(65 proof)*
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will be found to be less adherent in their beds than are those which were exercised." Recent published work advocates mobilization of the fingers on the tenth day to prevent such adherence.

In several places the information is sketchy and not in accord with the latest methods of treatment. The eschar treatment of burns with tannic acid and gentian violet is described in such a way as to imply that the author is still using it in certain cases. The section on free skin grafts, particularly of the split thickness variety, hardly does them justice. His section on tube and pedicle grafts, which he favors, is excellent, however, and covers the subject more completely than some books on plastic surgery. The parts dealing with fractures and dislocations and reconstructive bone surgery represent chiefly brief summaries of work that is already familiar. The discussions of keloids and amputations are also weak points.

Other fine sections are those on the anatomy and physiology of the normal hand, the examination of the hand, principles of operative technique, Dupuytren's and Volkmann's contractures, nerves of the arm and hand and injuries, and tumors of the hand. The last of these sections is by L. D. Howard, Jr. The Phylogeny and Comparative Anatomy and on Congenital Deformities seem to have been included more for the sake of completeness than anything else.

The final impression derived from this book is that the author sees the hand in terms of its whole function and as a part of the entire upper extremity. The arm in treatment is an early restoration of good function, although cosmetic effects are not disregarded. The operative technique is in accord with the atraumatic principles which are being more widely accepted each year. It is greatly to the author's credit that he was among the first to emphasize these principles and that he has taken this opportunity to bring them to what should be a wide audience.

*A TEXTBOOK OF OPHTHALMOLOGY.* (Third Edition, Revised.) *By Sanford R. Gifford*, M.A., M.D., F.A.C.S., Formerly Professor of Ophthalmology, Northwestern University Medical School, Chicago; Formerly Attending Ophthalmologist, Passavant Memorial and Cook County Hospitals. *Philadelphia: W. B. Saunders Company.* 457 pp. with 215 illustrations and 13 color plates. 1945. $4.00.

Reviewed by EUGENE M. BLAKE

The first edition of Gifford's book, published in 1938, was well received by the medical public and especially by teachers of undergraduate ophthalmology. The second edition was an improvement upon the first, and the third edition is a really excellent textbook. The subject matter is concisely presented and as fully as is possible in a small volume. The addition of many new colored plates adds greatly to the value of the book. Possibly more space is devoted to surgery of the eye than is necessary in a text intended for the medical student and the non-ophthalmologist. The index is exceptionally complete, a thing which is always appreciated by one looking up a subject. Gifford's Textbook ranks with the best of the smaller volumes on ophthalmology.

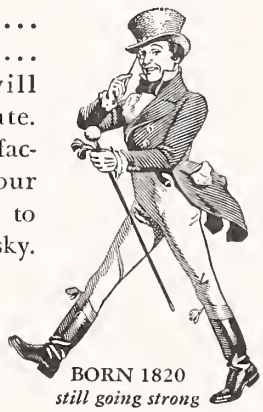



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# CHARTER AND BY-LAWS — CONNECTICUT STATE MEDICAL SOCIETY

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. The charter of The Connecticut Medical Society, approved June 5, 1834, is amended to read as follows: All persons who are, at the time of the passage of this act, members of The Connecticut Medical Society and all physicians and surgeons who shall hereafter be associated with them in pursuance of the provisions of this act shall be and remain a body politic and corporate by the name of The Connecticut State Medical Society; and by that name they and their successors shall and may have perpetual succession; shall be capable of suing and being sued, pleading and being impleaded, in all suit of whatever name and nature; may have a common seal and may alter the same at pleasure and may also purchase, receive, hold and convey any estate, real and personal, to an amount not exceeding one hundred thousand dollars.

Section 2. The superintendence and management of the corporation shall be vested in a board to be known as "The House of Delegates of The Connecticut State Medical Society," which board shall have power to establish officers in said corporation and prescribe the duties of the several officers and of the members of said corporation and may fix their compensation; to establish the conditions of admission to and dismission and expulsion from said society; to lay a tax, from time to time, upon the members and to collect the same; to hold and dispose of all moneys and other property belonging to the corporation in such manner as it may deem advisable to promote the objects and interests of the society and in general to make such by-laws and regulations for the due government of the society, not repugnant to the statutes of the United States or of this state, as may be deemed necessary.

Section 3. The House of Delegates of the Connecticut State Medical Society shall be composed of, (1) the President, the President-Elect, Treasurer and Secretary of the Society, (2) delegates to be elected annually as hereinafter provided, by the several county medical associations in this State which heretofore have been and are affiliated with the Connecticut State Medical Society and (3) the members of the Council of the Society.

Section 4. An annual meeting of the corporation, for the election of officers and such other business as may, from time to time, arise, shall be held upon such day in each year as The House of Delegates shall, from time to time, prescribe. Notice of such annual meeting date shall be sent to every affiliated county medical association at least sixty days before each annual meeting date so prescribed.

Section 5. At a meeting to be held at least twenty days in advance of the annual meeting of the corporation in each year, every affiliated county association shall elect a delegate or delegates to represent it in "The House of Delegates" of this society in the proportion of one delegate to each thirty-five members, or any part of that number, and the secretary of such affiliated county association shall send a list of such delegates to the secretary of this corporation at least twenty days before the date of such annual meeting.

Section 6. There shall be in "The House of Delegates," one councilor from each affiliated county medical association. The councilors holding office at the time of the passage of this act shall serve out the terms of office for which they were elected. At their annual meeting to be held in 1931, the affiliated county medical associations for the counties of Hartford, New London, Windham, and Middlesex shall each elect one councilor who shall serve for two years, and at their annual meeting in 1932 the affiliated county medical associations for New Haven, Fairfield, Litchfield and Tolland counties shall each elect one councilor, who shall serve for two years. Thereafter each county, in groups as above mentioned, shall, biennially, elect a councilor to fill said office for a term of two years. Any vacancy in said office may be filled by the county association of the county in which the vacancy occurs, by election to fill the unexpired portion of the term.

Section 7. The secretary of each affiliated county medical association in this state, shall, within ten days following any meeting of such association at which new members are elected, file with the secretary of the society a list of all members of such association who are at the time in good and regular standing and thereupon all such persons shall become members of The Connecticut State Medical Society without further action.

## BY-LAWS

### ARTICLE I

#### Name

*Section 1. Name*

Par. 1. The name of this organization shall be The Connecticut State Medical Society.

### ARTICLE II

#### Purposes

*Section 1. Purposes*

Par. 1. The purpose of this Society shall be to federate and bring into one organization the medical profession of the State of Connecticut; to unite with similar societies in other states to form the American Medical Association; to extend medical knowledge and advance medical science, to elevate the standard of medical education, and to promote friendly intercourse among physicians, to enlighten and direct public opinion so that the profession shall become increasingly useful to the public in the prevention and care of disease and in prolonging and adding comfort to life.

Par. 2. The Society is not organized, and shall never be maintained and conducted for the pecuniary profit of its members, officers, or employees but shall be, and remain, a strictly scientific and educational corporation, and no member, officer or employee of the Society shall at any time receive or be entitled to receive any pecuniary profit from the operation of the Society except a reasonable compensation for services actually rendered.

## ARTICLE III
### Ethics
*Section 1. Ethics*

Par. 1. The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

## ARTICLE IV
### Component Associations
*Section 1. Component Associations*

Par. 1. The county medical associations in the following counties shall be the component associations of The Connecticut State Medical Society: Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham.

## ARTICLE V
### Membership
*Section 1. Membership*

Par. 1. The Society shall consist of members, student members, associate members and honorary members.

*Section 2. Members*

Par. 1. All members in good standing in the component associations shall be members of this Society. Physicians whose names are on the official roster of membership of a component association shall be considered in good standing.

*Section 3. Student Members*

Par. 1. Any person whose legal or family residence is in the State of Connecticut who is a regularly enrolled student and a candidate for the degree of Doctor of Medicine in an acceptable medical school, as provided in Section 478f of the Cumulative Statutes of Connecticut, or any person who is a student in an acceptable medical school located in the State of Connecticut may become a Student Member of the Society. Also, physicians not licensed to practice medicine in Connecticut who are serving as interns or residents in hospitals in Connecticut, for the purpose of extending their education and not primarily for remuneration, may become Student Members of the Society.

Par. 2. Such membership shall be obtained by applying to the Council of the Society on a form provided for that purpose and election by vote of a majority of the Council.

Par. 3. Student Members shall enjoy all of the rights and privileges of membership in the Society except that they shall not be eligible to vote or hold office, and Student Members shall pay no dues.

Par. 4. When such a Student Member is licensed to practice medicine in the State of Connecticut and settles in this State in practice or remunerative employment he shall be eligible at once for election to active membership in the County Association in the County in which he has settled without the waiting period of residence within the County, subject to such regulations as may be imposed by such County Associations.

*Section 4. Associate Members*

Par. 1. Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut, may be elected as Associate Members in this Society by majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership which shall be passed upon by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all of the rights and privileges of the Society except that they may not vote or hold elective office; they may be appointed to serve upon committees and present papers before the Society or any of its sections.

*Section 5. Honorary Members*

Par. 1. Eminent physicians may be elected Honorary Members by majority vote of the House of Delegates in accordance with Article X, Section 3, Paragraph 4. They shall be accorded the privilege of participating in scientific work.

## ARTICLE VI
### Officers
*Section 1. Officers*

Par. 1. The officers of this Society shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, an Executive Secretary, a Treasurer, the Editor-in-Chief of the Journal, the elected Delegates to the American Medical Association, and eight Councillors.

Par. 2. The officers, except the President and the Councillors, shall be nominated by the Council and elected annually by ballot of the House of Delegates.

Par. 3. The President-Elect shall be elected annually. He shall serve as President-Elect until the annual session of the Society next ensuing after his election and shall become President upon his installation in the course of that session, serving thereafter as President until the next following annual session and the installation of his successor.

Par. 4. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in Hartford, New London, Windham and Middlesex counties in the odd years.

Par. 5. A Councillor who shall serve for two years shall be elected at the annual meeting of each of the county associations in New Haven, Fairfield, Litchfield and Tolland counties in the even years.

Par. 6. Any vacancy in the office of Councillor shall be filled by the county association in which the vacancy occurs.

*Section 2. Duties of Officers*

Par. 1. The President shall preside at meetings of the Society and at meetings of the House of Delegates, shall appoint all committees not otherwise provided for, shall visit the various medical associations throughout the state and shall present an annual address before the Society at a time to be arranged by the Program Committee.

Par. 2. The duties of the President-Elect shall be to aid and assist the President.

Par. 3. The Vice-President shall assist the President in the discharge of his duties, preside at meetings in the absence of the President, or on his request. In the event of a vacancy in the office of President, that office shall be filled for the remainder of the unexpired term by the First Vice-President and he will be succeeded by the Second Vice-President.

Par. 4. The Executive Secretary shall attend the meetings of the House of Delegates, shall verify the eligibility

and record the presence of members of the House of Delegates and keep minutes of its proceedings. He shall serve as secretary of the Council and keep a record of its proceedings. He shall provide for the registration of members and delegates at the annual sessions; he shall, with the cooperation of the secretaries of the component associations, keep a card index roster of all the legal practitioners of medicine in the State by counties, noting on each his status in relation to his county association, and, on request, shall transmit a copy of this list to the American Medical Association. He shall cooperate with the officials of the county associations in the extension of the usefulness of the Society. He shall conduct official correspondence of the Society, notify members of meetings, officers of their election and committees of their appointment and duties. He shall make payment of necessary expenditures from funds allocated by the Treasurer and shall employ such assistance as may be approved by the Council. He may, upon request, supply each component association with the necessary blanks for application for membership and with blanks for making their annual reports. In cooperation with a Program Committee he shall publish and distribute all official programs.

Par. 5. The Treasurer shall receive all funds due the Society and shall receive bequests and donations on behalf of the Society. He shall remit periodically to the Executive Secretary and to the Editor of the JOURNAL prorated portions of the funds allocated to these officers for the operation of their offices. All other payments by him shall be subject to a written order of the Chairman of the Council, or, in his absence, the President of the Society. The Treasurer shall give bond in a sum and manner of bonding prescribed by the Council. He shall make a report to the House of Delegates at the annual session.

Par. 6. The Editor-in-Chief of the JOURNAL, in addition to the recognized duties of such an office, shall make payment of necessary expenditures from funds allocated to the JOURNAL by the Treasurer. His report of expenditures shall be included in the report of the Treasurer to the House of Delegates at its annual meeting.

## ARTICLE VII

### MEETINGS

#### *Section 1. Annual Meetings*

Par. 1. The Society shall hold an Annual Session during which there shall be held Scientific Meetings which shall be open to all registered members and guests.

Par. 2. The time and place for holding each annual session shall be fixed by the Council.

#### *Section 2. Special Meetings*

Par. 1. Special meetings of the Society or House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

#### *Section 3. Recommendations*

Par. 1. Recommendations made by any Scientific Session or Section Meeting may be submitted to the House of Delegates.

## ARTICLE VIII

### HOUSE OF DELEGATES

#### *Section 1. House of Delegates*

Par. 1. The House of Delegates shall be the legislative and business body of the Society and shall be empowered to carry out the purposes of the Society. It shall consist of the delegates elected by the component county associations and the members of the Council.

Par. 2. Each component association shall be entitled to send to the House of Delegates each year one delegate for every thirty-five members or any additional part of that number. A component county association with less than thirty-five members shall be entitled to one elected member of the House of Delegates.

#### *Section 2. Duties*

Par. 1. The House of Delegates shall elect Delegates and Alternate Delegates from the Society to the House of Delegates of the American Medical Association in accordance with the constitution and by-laws of that body. These Delegates and Alternates shall take office on the first of January following their election and shall serve terms of two years.

Par. 2. The House of Delegates shall have authority to appoint committees for special purposes from among the members of the Society. Such committees shall make written report through the Council to the House of Delegates, and members of these committees may attend meetings of the House of Delegates and participate in the discussion of reports submitted by them.

Par. 3. The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections.

Par. 4. No memorial or resolution shall be issued in the name of the Society without first having been approved by the House of Delegates.

#### *Section 3. Meetings*

Par. 1. The Annual Meeting of the House of Delegates shall be called by the Council and shall be held during the week of the Annual Session of the Society. The order of business shall be arranged as a separate section of the program by the Council. The President of the Society shall preside at all meetings or designate one of the Vice-Presidents to preside in his absence.

Par. 2. A Semi-Annual Meeting shall be held when required at a place and date to be set by the Council.

Par. 3. Special Meetings of the House of Delegates may be called by the President or by the Council and shall be called by the President on petition of ten members of the House of Delegates or fifty members of the Society.

Par. 4. Twenty-five delegates shall constitute a quorum.

## ARTICLE IX

### THE COUNCIL

#### *Section 1. Membership*

Par. 1. The Council shall consist of one Councillor from each County and the President, the President-Elect, the Executive Secretary, the Treasurer, the Editor-in-Chief of the JOURNAL and the Delegates to the American Medical

Association. Seven members of the Council shall constitute a quorum for the transaction of business.

*Section 2. Meetings*

Par. 1. The Council shall meet at least once in two months throughout the year, except during the months of July, August and September, and at such other times as it may be called by the Chairman of the Council or upon petition of three members of the Council. It shall have its Annual Meeting for the purpose of organizing and the election of a chairman at its first meeting following the Annual Meeting of the House of Delegates.

*Section 3. Duties*

Par. 1. The Council shall have the power to act for the House of Delegates between meetings of that body and shall report such action to the House of Delegates at its next meeting.

Par. 2. The Council shall be the Nominating Committee of the Society and it shall report as such to the first session of the Annual Meeting of the House of Delegates. After the report has been made an opportunity shall be given for other nominations to be made.

Par. 3. The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, in relation to other members, to the component associations, or to this Society. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component associations on which an appeal is taken, and its decision in all such matters shall be final.

Par. 4. The Council shall serve as a Board of Review for cases of claimed malpractice referred to it by the Committee on Medical Ethics and Deportment of any component County Association.

Par. 5. The Council shall be the Finance Committee of the Society and shall superintend and direct all financial transactions of the Society and shall prepare and submit annually to the House of Delegates a budget for the operation of the Society.

Par. 6. The Council shall make an Annual Report to the House of Delegates.

## ARTICLE X

### Committees

*Section 1. Standing Committees*

Par. 1. The Standing Committees of the Society shall be as follows:

A Committee on Arrangements.
A Committee on the Clinical Congress.
An Editorial Board of the Journal.
A Committee on Honorary Members and Degrees.
A Committee on Hospitals.
A Committee on Industrial Health.
A Committee on Medical Education and Licensure.
A Program Committee.
A Committee on Public Health.
A Committee on Public Policy and Legislation.
A Committee on Public Relations.
A Committee on Tumor Study.

Par. 2. Unless otherwise specified in these by-laws, nominations for these committees and their chairmen shall be made by the Council and presented to the Annual Meeting of the House of Delegates.

Par. 3. All standing committees except the Committee on Arrangements shall make annual written reports to the Council before the first of April of each year for transmittal with recommendations to the Annual Meeting of the House of Delegates.

*Section 2. Special Committees*

Par. 1. Special Committees may be appointed by the Council or elected by the House of Delegates as may from time to time be required. Committees appointed by the Council shall make written reports to the Council as directed by it. Committees elected by the House of Delegates shall make written reports to the Council in the same manner as provided for standing committees.

*Section 3. Duties of Committees*

Par. 1. The Committee on Arrangements shall be appointed by the component association with which the Annual Session of the Society is to be held. It shall provide suitable accommodations for the meeting places of the Society, and of the Special Sections, and of the House of Delegates, and of their respective committees. Its chairman shall report an outline of the arrangements to the Executive Secretary for publication in the program.

Par. 2. The Council shall nominate to the House of Delegates each year a Committee on the Clinical Congress, and its Chairman, a Secretary and a Treasurer. The function of the committee shall be the arrangement and direction of the annual Clinical Congress of the Society and such other activities in postgraduate instruction as may from time to time appear desirable to the committee. The Chairman, the Secretary and the Treasurer shall be the trustees of the funds of the Clinical Congress, and this Committee, through its Treasurer, shall receive income from registration fees of the Congress and other sources of income incident to the administration of the Congress, and pay therefrom all necessary expenses. This fund shall be audited by the Society's auditors and a report of the transactions of the fund for the fiscal year shall be rendered by the Treasurer of the Clinical Congress to the House of Delegates each year at its Annual Meeting. The Treasurer of the Clinical Congress shall give bond in a sum and manner of bonding prescribed by the Council. He shall remit to the general fund of the Society such part of the funds of the Clinical Congress as the Council from time to time may direct.

Par. 3. The Council shall nominate to the House of Delegates each year an Editorial Board for the Journal consisting of five members, and nominate the Chairman of the Board who shall serve as Editor-in-Chief of the Journal. The Editor-in-Chief shall be a member of the Council. In addition to the Board so nominated, the President of the Society shall serve as an ex-officio member with all rights and privileges of other members during the term of his office. The Editorial Board shall edit and publish the Connecticut State Medical Journal and shall determine its advertising policy, all in a manner to promote the best interests of medicine.

Par. 4. The Committee on Honorary Members and Degrees shall consist of the three latest Past Presidents of the Society. This Committee may present annually to the House of Delegates the names of not more than three eminent physicians as candidates for honorary membership in the Society. The Committee may recommend the bestowal of an honorary degree in medicine upon any person not a physician, distinguished in the sciences of medicine or for contribution in human welfare.

Par. 5. The Council shall nominate annually to the House of Delegates a Committee on Hospitals to consist of not less than six members, and shall nominate the Chairman thereof. This Committee shall pursue a continuing study of the relation of the medical profession to the operation of public and voluntary hospitals within this state and shall, when indicated, confer with the State Department of Health and representatives of the Connecticut Hospital Association and make recommendations to the Society.

Par. 6. The Council shall nominate to the House of Delegates annually a Committee on Industrial Health to consist of not less than ten members, and nominate the Chairman thereof. The function of this Committee shall be to inquire into health in industry with the purpose of making information on the subject available to the members of the Society and all other persons interested in improving health and hygiene of persons employed in industry.

Par. 7. At each annual meeting the Council shall nominate to the House of Delegates a member of the Society to be proposed to the Governor of the State of Connecticut for appointment as a member of the Connecticut Medical Examining Board for a term of five years in accordance with Section 2748 of the General Statutes of 1930 as amended. During the month of December of each year the Executive Secretary of the Society shall prepare a statement informing the Governor of the Society's choice of a member to be appointed as a member of the Connecticut Medical Examining Board, and, after obtaining the signature of the President of the Society on this statement, it shall be delivered to the Governor. In the event of a vacancy on the Connecticut Medical Examining Board and when it is not practicable to have the choice of another member of the Society who is to be recommended to the Governor for appointment made by the House of Delegates, the President shall propose to the Governor a member of the Society for appointment. The Connecticut Medical Examining Board shall constitute the Society's Committee on Medical Education and Licensure and the President of that Board as elected by its members shall be the Chairman of the Society's Committee. The function of the Committee on Medical Education and Licensure shall be to study the educational and legal requirements for practitioners of medicine in the State of Connecticut, to provide information for the members of the Society on these and related subjects, and, as occasion arises, to recommend to the Society amendments to the statutes regulating the practice of medicine within this state and the maintenance of a high quality of medical care in Connecticut.

Par. 8. The Program Committee shall consist of three members, one member of which shall be nominated annually by the Council for election by the House of Delegates for a term of three years. The Chairman of the Committee shall be the member who is serving the final year of his term of office. The duties of this Committee shall be to arrange the scientific program for the meetings of the Society and it shall prepare such program for the annual meeting and submit it to the Executive Secretary of the Society for publication not less than two months preceding the date of the meeting.

Par. 9. The Council shall nominate to the House of Delegates annually one member from each component county association and such additional members as it may determine not to exceed fifteen to be the Committee on Public Health and nominate the Chairman thereof. The Committee on Public Health shall be the representative of the Society in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. It shall confer from time to time with the Connecticut State Health Department and other legal public health authorities in a manner mutually agreeable, and it shall inform the Society concerning matters of public health and, as occasion arises, recommend for the Society's consideration desirable legal enactments to promote public health within the State.

Par. 10. The Council shall nominate to the House of Delegates annually a Committee on Public Policy and Legislation not to exceed fifteen members and nominate the Chairman thereof. The Committee shall include one representative from each of the eight component county associations of the Society and the Delegates from this Society to the American Medical Association. The Executive Secretary of the Society shall be a member of this Committee and serve as its executive officer. The function of this Committee shall be to review and advise the members of the Society concerning proposed state and national legislation pertaining to the public health, welfare and the practice of medicine. It shall, as occasion arises, draft and have introduced into the General Assembly of this State appropriate legislation for improving medical care and the public health within the State, advise the Society's legislative agent concerning the opinion of the Society on pending legislation and supervise and direct the Society's program in the legislative field.

Par. 11. The Council shall nominate to the House of Delegates annually a Committee on Public Relations to consist of eight members and nominate the Chairman thereof. The function of this Committee shall be to inquire into and pass upon such phases of public information as deal with the care of the sick and the practice of medicine, and shall endeavor to keep the people of Connecticut accurately and reliably informed concerning matters of public interest in the field of medicine. The Committee shall use its efforts to encourage cordial relations and understanding with the public press and radio. and cooperate with other committees of the Society in a program of public relations.

Par. 12. The Council shall nominate to the House of Delegates annually a Committee on Tumor Study of not less than fifteen members and nominate the Chairman thereof. The function of this Committee shall be a continuing study of the problem of malignant disease within the state, to inform the members of the Society concerning developments in this field, to encourage and increase accuracy in the recognition and treatment of malignant tumors, to cooperate with the Connecticut State Department of Health and other

public and private agencies in the establishment and maintenance of diagnostic tumor clinics for service to indigent persons within the state, and as occasion arises make recommendations to the Society concerning legislation in this field.

## ARTICLE XI

### Funds and Expenses

#### *Section 1. Funds*

Par. 1. Funds for the operation of the Society shall be raised by an equal annual per capita assessment from each member of a component county association, except:

Par. 2. Members who are elected to the county associations at the semi-annual meetings will be assessed one half of the annual dues for the year of their election.

Par. 3. Members who have been in good standing in the Society for forty consecutive years or who have attained the age of sixty-eight and shall have been members of the Society for fifteen years immediately preceding, shall, upon written request addressed to the Treasurer of the Society, be exempt from further payment of dues and shall continue as active members of the Society enjoying all rights and privileges.

Par. 4. The dues of any member may be remitted by a majority vote of the House of Delegates.

Par. 5. All funds of the Society shall be deposited promptly upon receipt in a state or national bank located in the State of Connecticut.

Par. 6. The fiscal year of the Society shall commence on January 1 and terminate on December 31 of each year.

#### *Section 2. Budget*

Par. 1. The annual budget of the Society shall be prepared by the Council, as the Finance Committee of the Society, and be presented to the House of Delegates for approval. Based upon that budget the Council shall recommend to the House of Delegates the amount of per capita assessment for the ensuing fiscal year. All requests and resolutions appropriating funds of the Society shall be referred to the Council for recommendation to the House of Delegates and all such requests and recommendations must be approved by the House of Delegates before funds may be expended.

#### *Section 3. Fidelity Bonds*

Par. 1. The Council shall prescribe and provide at the expense of the Society proper fidelity bonds for officers of the Society and other persons responsible for the receipt, custody and disbursement of funds belonging to the Society.

## ARTICLE XII

### Referendum

#### *Section 1. Referendum*

Par. 1. A General Meeting of the Society may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such questions to the members of the Society who may vote by mail or in person, and, if the members voting shall comprise a majority of all the members of the Society, a majority of such vote shall determine the question and be binding on the House of Delegates.

Par. 2. The House of Delegates may, by a two-thirds vote of its members present, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

## ARTICLE XIII

### Component County Associations

#### *Section 1. Component County Associations*

Par. 1. The County Medical Associations in Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland and Windham Counties now in operation and in affiliation with The Connecticut State Medical Society shall be the component county associations of this Society.

#### *Section 2. Function*

Par. 1. The function of the component medical associations shall be to bring together into one organization the physicians of each county and these associations shall be united for the purpose of organizing the medical profession in the State of Connecticut as provided in Article II, Section 1 of these By-Laws.

#### *Section 3. Eligibility for Membership*

Par. 1. All registered physicians licensed under Article 2747 of the General Statutes of the State of Connecticut, 1930, as amended, who have resided and practiced under that license in the State of Connecticut for one year shall be eligible to apply for membership except that student members transferring to active membership as provided in Article V, Section 3, Paragraph 4, shall not be required to reside in Connecticut one year before becoming eligible.

#### *Section 4. Application for Membership*

Par. 1. A physician who desires to become a member of a county medical association shall obtain from the Secretary of that association an application form which, when completed, shall be returned to the Secretary. A physician living near a county line may hold membership in that county most convenient for him on permission of the association in whose jurisdiction he resides.

#### *Section 5. Transfer of Membership*

Par. 1. A member of a component association of the Society who removes his residence to another county within this state and who wishes to transfer his membership to the county association in the county of his new residence may do so upon the presentation of a certificate signed by the Secretary of the county association of which he is a member. This certificate shall state that he is a member in good standing in the association of the county where he previously resided and that his financial obligations to that association for the current year have been paid. The certificate shall be accompanied by a regular application for membership. The association in the county of his new residence shall add him to the rolls of that association without formality and without charging any dues for the remainder of the year of his transfer.

Par. 2. A member of a state medical society in another state, that is a component of the American Medical Association, wishing to transfer his membership to a component county association of this Society shall present to the Secretary of the component association of this Society in which

he is seeking membership a certificate from the Secretary of the county or state medical society of his previous residence. This certificate shall state that he is a member in good standing in that county or state medical association. This certificate and a properly completed application for membership shall be forwarded to the Board of Censors or Credential Committee of the component association in this State in which he is seeking membership and that Board of Censors or Committee on Credentials may recommend his election at the next meeting of the component association without regard to the residence requirement prescribed in Section 3 of this Article.

*Section 6. Membership Roster*

Par. 1. The Secretary of each component association shall keep an individual record of the members of that association, and this record shall include the full name, address, college degrees with year, medical schools attended with school and year of graduation, hospital affiliations, type of special practice, if any, and date of registration in this state. Notations shall also be made concerning transfer and termination of membership.

*Section 7. Discipline*

Par. 1. Any member of a component county association who is aggrieved by disciplinary action of the county association of which he is a member shall have the privilege of appealing to the Council of the Society which shall review the charges made against the disciplined member and the findings therein and render a decision concerning the disciplinary action taken; this decision shall be final.

*Section 8. Termination of Membership*

Par. 1. When membership in a component county association terminates for any cause, membership in the Connecticut State Medical Society shall be terminated automatically as of the same date.

*Section 9. Delegates to the House of Delegates of the Society*

Par. 1. Each component county association shall be represented in the House of Delegates of the Society on the basis of one delegate for each thirty-five members and any additional part of that number. The component association with less than thirty-five members shall be entitled to one elected delegate.

Par. 2. On or about the 15th of March of each year the Executive Secretary of the Society shall inform the Secretary of each of the component associations of the number of members in good standing in each component association on the 31st of December just preceding, and compute therefrom the number of delegates to which each county association is entitled for the ensuing year.

Par. 3. At least twenty days prior to the Annual Meeting of the House of Delegates the Secretary of each component association shall inform the Executive Secretary of the Society of the names and addresses of the officially elected and qualified delegates from each county association.

Par. 4. In case of the inability of a regularly elected delegate to attend meetings of the House of Delegates, the President or the Secretary of the county association in which the vacancy occurs shall appoint an alternate delegate, with full power to represent that county association during the interim, or until the successor of such regularly elected delegate is elected. Upon the appointment of such alternate delegate, the Secretary of the county association in which the appointment is made shall inform the Executive Secretary of the State Society of the appointment at once and before the alternate delegate may be seated in the House of Delegates.

*Section 10. Dues*

Par. 1. Any of the component county associations may at its option collect the annual dues assessed by the Society in conformity with regulations established by the Treasurer of the Society. Bills for these dues shall be rendered to all members immediately following January 1st of each year and the component county associations shall forward all monies so collected on behalf of the Society to the Treasurer of the Society quarterly and at such other times as the Treasurer may direct and they shall accompany all payments with a report on a form to be provided by the Treasurer.

Par. 2. If a component county association does not elect to collect the annual dues assessed by the Society as provided in Paragraph 1 above, the Treasurer of the Society shall collect the annual dues assessed by the Society from the members of that component county association and collect also the dues assessed by that county association. In that event the Treasurer of the Society shall remit to the county association periodically all monies collected on behalf of that association and shall file an accounting of all county association assessments so collected for the year just closed with the county association before the 15th of January of each year.

*Section 11. By-Laws*

Par. 1. The component county associations shall have the power to adopt only such By-Laws as are not in conflict with the By-Laws of The Connecticut State Medical Society. In the event of an existing or apparent conflict the By-Laws of the Society shall take precedence over those of a component county association.

## ARTICLE XIV

### Amendments

*Section 1. Amendments*

Par. 1. The By-Laws of the Society may be amended by a majority vote of the total number of the members of the House of Delegates.

Par. 2. Proposed amendments to the By-Laws shall be submitted first to the Council and published, with the Councils recommendation, in The Connecticut State Medical Journal at least one month prior to the date of the meeting of the House of Delegates at which action thereon is to be taken. Copies of the proposed amendments shall also be forwarded to each member of the House of Delegates in the notices of the meeting at which the amendments are to be acted upon.

## ARTICLE XV

### Parliamentary Procedure

*Section 1. Rules of Order*

Par. 1. In all matters of parliamentary procedure the Society shall be governed by Roberts Rules of Order.

*Section 2. Enablement Clause*

Par. 1. The adoption of these By-Laws rescinds and revokes all previous By-Laws of the Society and supercedes their operation.

# ROSTER OF MEMBERS, 1945

*Member reported to be in the Army, Navy or Public Health Service as of July 5, 1945
†Member returned to civilian status from military service as of July 5, 1945

## CONNECTICUT STATE MEDICAL SOCIETY OFFICERS

*President:* Joseph H. Howard, Bridgeport
*President-elect:* Cole B. Gibson, Meriden
*First Vice-President:* Arthur H. Jackson, Washington
*Second Vice-President:* Louis P. Hastings, Hartford
*Executive Secretary:* Creighton Barker, New Haven
*Treasurer:* Hugh B. Campbell, Norwich
*Editor of the Journal:* Stanley B. Weld, Hartford

## Fairfield County Association

*President:* George B. Garlick, 144 Golden Hill St., Bridgeport
*Vice-President:* John D. Booth, 173 Main St., Danbury
*Secretary:* J. Grady Booe, 144 Golden Hill St., Bridgeport
*Treasurer:* Clifton C. Taylor, 881 Lafayette St., Bridgeport
*Councilor:* Samuel F. Mullins, 116 Main St., Danbury

Annual Meeting, Second Tuesday in April, at Bridgeport
Semi-Annual Meeting, First Wednesday in October

### BETHEL

1940 *Grigas, John E., 218 Greenwood Ave.
1925 Moore, Homer Franklin, 4 Grand Ave.
1938 Trimpert, Albert J., 155 Greenwood Ave.
1939 *Wolfson, Dexter, 58 Greenwood Ave.

### BRIDGEPORT

1933 Adzima, Joseph Matthew, 409 Noble Ave.
1941 Akerson, Irving B., Bridgeport Hospital
1932 *Alpert, Max, 881 Lafayette
1944 Amarant, Leo, 881 Lafayette
1935 *Antell, Maxwell Joseph, 1690 Barnum Ave.
1920 Apsel, Abraham, 1620 Fairfield Ave.
1928 Backer, Marcus, 881 Lafayette
1938 *Bakunin, Maurice Irving, 881 Lafayette
1916 Banks, Daniel Tony, 385 Barnum Ave.
1913 Beaudry, Joseph Horace, 109 Rowsley
1941 Beck, Sidney Henry, 881 Lafayette
1941 *Bellew, Raymond F., 472 State
1913 Bernstein, Abraham, 881 Lafayette
1935 Bogin, Maxwell, 144 Golden Hill
1921 Booe, John Grady, 144 Golden Hill
1941 *Brier, Hyman D., 2583 Main
1927 Brodsky, Michael Emanuel, 881 Lafayette
1940 Brooks, Paul Lester, 1260 East Main
1943 Brunet, Walter M., Bridgeport Brass Co.
1939 *Buckhout, George Atherton, 144 Golden Hill
1938 †Buckley, John William, 2080 North Ave.
1923 Buckmiller, Frank Charles, 1119 Stratford Ave.
1940 Burns, Bernard J., 636 West Taft Ave.
1943 *Cacace, Vincent Anthony, 835 Fairfield Ave.
1919 Calvin, Claudius Virgil, 144 Golden Hill
1945 Capobianco, Arthur Paul, 932 East Main
1920 Carroll, Francis Patrick, 919 Fairfield Ave.
1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.
1940 *Castaldo, Louis F., 47 Goodsell
1920 Cheney, Maurice Lionel, 144 Golden Hill
1941 *Clark, William Thompson, 881 Lafayette
1924 Conklin, Cornelius Stephen, 468 Clinton Ave.
1936 †Connors, Edwin Robert, 416 Boston Ave.
1935 Creaturo, Nicholas Edward, 1286 East Main
1943 Crispin, Maximilian A., 447 Queen
1913 Curley, William Henry, 881 Lafayette
1908 Curran, Philip John, 144 Golden Hill
1894 Day, Fessenden Lorenzo, 819 Myrtle Ave.
1920 DeLuca, Horatio Roger, 881 Lafayette
1935 Del Vecchio, Leonard Frederick, 932 East Main
1921 DeWitt, Edward Nicholas, 881 Lafayette
1941 *Duzmati, Paul Peter, 258 Kent Ave.
1941 *Eddy, Maxon Hunter, 881 Lafayette
1939 Edgar, Katherine Jean, 144 Golden Hill
1937 Eimas, Aaron, 881 Lafayette
1939 *Esposito, Joseph John, 126 Savoy
1938 *Findorak, Francis George, 230 Hickory
1943 Fink, Lisbeth, 2574 Main
1913 Finkelstone, Benjamin Brooks, 144 Golden Hill
1938 Foley, Francis Xavier, 3100 Main
1908 Formichella, John B., 797 Washington Ave.
1916 Gade, Carl Johannes, 144 Golden Hill
1939 Gaffney, Charles Bernard, 610 Brooklawn Ave.
1929 Garbelnick, David Abraham, 1102 East Main
1907 Gardner, Charles Wesley, 144 Golden Hill
1916 Garlick, George Burroughs, 144 Golden Hill
1940 *Geer, William Allyn, 881 Lafayette
1916 Gilday, James Lowry, 819 State
1927 Gildea, Mark Andrew, 881 Lafayette
1895 Gold, James Douglas, 839 Myrtle Ave.
1943 Golomb, Evelyn Frances, 3461 Main
1927 *Greenspun, David Stoven, 144 Golden Hill
1916 Griffin, Daniel Patrick, 1278 East Main
1923 Griswold, Arthur Sheldon, 144 Golden Hill
1928 Griswold, Crawford, 144 Golden Hill
1920 Groark, Owen James, 881 Lafayette
1941 *Gulash, John Robert, 573 Stillman
1913 Hale, Fraray, 144 Golden Hill
1941 Hall, Rufus Warren, 66 Park
1939 *Hardenbergh, Daniel Bailey, 881 Lafayette
1937 *Harper, Paul, 144 Golden Hill
1928 Harshbarger, Isaac Long, 144 Golden Hill
1920 Havey, Leroy Austin, 144 Golden Hill
1938 Hennessey, Joseph Gerard, 482 Brewster
1915 Hippolitus, Paul DiFrancesca, 269 Barnum Ave.
1930 Hooper, G. Herbert, 881 Lafayette
1933 *Horn, Benjamin, 620 Clinton Ave.
1916 Horn, Martin Irving, 915 North Ave.
1920 Howard, Joseph Henry, 144 Golden Hill
1938 *Hurlburt, Edward Glens, 3366 Main
1912 Hyde, Charles Elias, 881 Lafayette
1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.
1944 Johnstone, Kermit T., 939 Barnum Ave.
1943 Jones, Elwood King, 881 Lafayette
1932 Kalman, Eugene, 622 Clinton Ave.
1942 Kaplan, Leon, 881 Lafayette

1941 Kaufman, William, 541 Brooklawn Ave.
1927 Keegan, Daniel Francis, 144 Golden Hill
1938 *Keys, Robert C., 881 Lafayette
1924 Kneale, Halford Benson, 144 Golden Hill
1924 *Kornblut, Alfred, 1539 Fairfield Ave.
1913 Lambert, Henry Bertram, Bridgeport Hospital
1943 Landecker, Norbert, 2895 Main
1926 Laszlo, Andras E., 881 Lafayette
1940 Lengyel, Paul, 500 Clinton Ave.
1943 Lesko, Joseph M., 144 Golden Hill
1925 Levenson, Albert, 881 Lafayette
1904 Leverty, Charles Joseph, 528 Park Pl.
1933 Levinsky, Maurice, 480 Noble Ave.
1927 Levy, Maurice Noel, 480 Clinton Ave.
1942 *Lieberthal, Milton M., 881 Lafayette
1940 Little, Olga A. G., 1278 East Main
1931 Lockhart, Reuben Harold, 144 Golden Hill
1937 Lynch, Hubbard, 881 Lafayette
1887 Lynch, John Charles, 826 Myrtle Ave.
1904 Lynch, Robert Joseph, 144 Golden Hill
1944 Lyon, Grover Arthur, 2009 North Ave.
1932 Marglis, Ben, 171 Harrison
1941 *Martin, Raymond Alfred, 654 Clinton Ave.
1942 *Massey, Daniel M., 1025 Noble Ave.
1922 Maxwell, John Alphonsus, 919 Stratford Ave.
1945 McGovern, Edward F., 881 Lafayette
1938 McLean, Thomas Smith, Jr., 1403 Boston Ave.
1913 McQueeney, Andrew Michael, 1315 Noble Ave.
1931 Meyer, Fritz Martin, 144 Golden Hill
1892 Miles, Henry Shillingford, 144 Golden Hill
1942 *Mitchell, Gerald Vincent, Remington Arms Co., Inc.
1940 *Monahan, David Tuite, 144 Golden Hill
1932 Mooney, Sydney, 881 Lafayette
1936 Murray, William J. C., 784 Noble Ave.
1938 Nespeco, James V., 3163 Main
1901 Nettleton, Irving La Field, 775 Washington Ave.
1919 Neumann, Harry Aaron, 588 State
1937 Newton, Louis, 881 Lafayette
1925 Nichols, Charles Williams, 1221 Stratford Ave.
1920 Nickum, John Stanley, 144 Golden Hill
1936 Nolan, John Francis, 1260 East Main
1926 Oberg, Frank Thorwald, General Electric Co.
1941 O'Connell, John Gabriel, 1950 Park Ave.
1943 O'Neill, John Joseph 1468 Stratford Ave.
1944 Oros, Louis Michael, 1005 State
1944 Oster, Kurt A., 881 Lafayette
1940 *Panettieri, Andrew Joseph, 3084 Main
1921 Parmelee, Berkley Melvin, 144 Golden Hill
1937 Pascal, Thomas J., 1560 Noble Ave.
1944 Pasquariello, Domenico William, 2969 Main
1909 Patterson, Daniel Cleveland, 881 Lafayette
1930 Pileggi, Peter, 743 Washington Ave.
1935 Plukas, Joseph Martin, 339 South Ave.
1942 *Popkin, Michael Sherman, 3223 Main
1941 Pratt, George Kenneth, 881 Lafayette
1933 †Quatrano, Joseph Charles, 893 Clinton Ave.
1916 Quinn, John Francis, 144 Golden Hill
1941 Quinn, Katherine Sarah, 2970 North Main
1916 Reich, Upton Sharetts, 2095 Main
1940 *Reiter, Benjamin Reynolds, 144 Golden Hill
1942 Resnik, Harry, 881 Lafayette
1938 *Ribner, Harold, 881 Lafayette
1918 Roberts, Edward Russell, 144 Golden Hill
1913 Roche, Thomas Joseph, 1815 Noble Ave.
1936 Rockwell, Alice Elizabeth, 1775 Noble Ave.
1944 Rosenberg, Hans August, 2646 North Ave.
1942 Scalzi, Leonard Conrad, 932 East Main
1943 Sciortino, Michael Vincent, 2072 North Ave.
1928 Sekerak, Arthur Joseph, 408 Barnum Ave.
1938 Sekerak, Raymond Andrew, 1400 East Main
1938 Sekerak, Richard John, 938 East Main
1938 *Shea, Cornelius Joseph, 1153 Park Ave.
1913 Shea, John Francis, 144 Golden Hill
1944 Sholler, Nicholas A., 2148 North Ave.
1935 Smith, Joseph Jacob, 1280 Stratfield Rd.
1919 Smith, Stanton Reinhart, 144 Golden Hill
1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.
1930 *Sollosy, Alexander, 645 Bostwick Ave.
1941 Spinelli, Nicholas Victor, 1285 Noble Ave.
1909 Sprague, Charles Harry, 29 Hanover
1935 *Strayer, Luther Milton, Jr., 955 Main
1940 Tarasovic, Thomas Joseph, Churchill Rd., R. F. D. 3
1920 Taylor, Clifton Clark, 881 Lafayette
1938 Ter Kuile, Roger Couvelle, 881 Lafayette
1925 Tolk, Nathan Robert, 558 Clinton Ave.
1942 Trautman, Edwin Frederick, 5385 Main
1929 Turchik, Frank, 1831 Barnum Ave.
1941 Tutles, Alexander James, 860 Clinton Ave.
1943 †Unger, Milton, 1025 Central Ave.
1932 *Uvitsky, Irving Harry, 3101 Main
1941 Vioni, R. Edward, 842 North Ave.
1923 Walsh, James Francis, 583 Noble Ave.
1942 †Ward, James P., 881 Lafayette
1903 Warner, George Howell, 144 Golden Hill
1920 Watts, Joseph Francis, 881 Lafayette
1913 Weadon, William Lee, 144 Golden Hill
1934 Wehger, Roland Theodore, 144 Golden Hill
1922 Weise, Ellwood Carl, 144 Golden Hill
1914 Weldon, Edwin Bernard, 144 Golden Hill
1936 Yeager, Charles Frederick, 2139 East Main
1935 *Zaur, Israel Sidney, 881 Lafayette
1943 Zsiga, Elmo Douglas, 303 Clinton

## DANBURY

1929 *Amos, Isadore Louis, 8 West
1929 Booth, John Dibble, 173 Main
1941 Brochu, Eugene Dalva, 229 Main
1902 Bronson, William Thaddeus, 41 West
1942 *DeKlyn, Ward B., 5 Wooster Heights
1928 Delohery, Cornelius Leo, 215 Main
1935 Driscoll, Jerome James, 206 Main
1937 *Eckert, George Robert, 394 Main
1931 *Gaffney, John James, 179 Main
1931 Genovese, Frank Thomas, 172 White
1938 Genovese, Serafino, 390 Main
1930 *Gibson, Donald Farnham, 75 West
1929 *Goldys, Frank Max, 209 Main
1897 Gordon, William Francis, 26 West
1940 Howard, Leonard Arnold, 87 West
1912 Moore, Howard Delano, Box 386
1912 Mullins, Samuel Frederick, 116 Main
1937 Murphy, James Joseph, 147 Main
1939 Murray, Thomas Oscar, 145 Deer Hill Ave.
1937 *Rogol, Louis, 85 West
1926 Selleck, Nathaniel Benedict, 215 Main
1913 Smith, Arthur Charles, 246 Main
1934 *Smith, Stephen Munro, R. F. D. #3, Candlewood Isle
1920 Stahl, William Martin, 343 Main
1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.
1929 Sunderland, William Alexander, 158 Deer Hill Ave.
1932 Tomaino, Felix Francis, 8 West

## DARIEN

1944 Huntington, Frederic Sargent, Middlesex and Hollow Tree Ridge Rd.
1941 *Moore, Gilbert Emerson, 162 Post Rd.

1940 Ross, Allan Maxwell, 188 Post Rd.
1943 Soley, Paul J., West Norwalk Rd.
1938 Van Tassel, Walter, 194 Post Rd.

## FAIRFIELD

1944 Barker, Daniel C., 133 Reef Rd.
1939 *Biehn, Donald M. Frick, 133 Reef Rd.
1928 Biehn, Sidney Lister, 22 Reef Rd.
1935 Davis, Thomas Francis, 703 Post Rd.
1938 Fulstow, Marjorie, 1275 Post Rd.
1944 Harris, H. Patterson, Jr., 1432 Post Rd.
1940 *Little, Mervyn Henry, 970 Old Post Rd.
1932 *Pitock, Morris Philip, 570 Post Rd.

## GREENS FARMS

1942 Paul, Francis, Box 31

## GREENWICH

1940 Adams, Mary, 40 West Elm
1935 Amoss, Harold Lindsey, 21 Field Point Rd.
1939 *Anderson, Clifton Winthrop, 116 East Elm
1938 *Carter, Gray, 29 Hillside Ave.
1943 Claps, Ludovic Vincent, 161 Mason
1933 Close, John Frederick, 66 Millbank Ave.
1944 *Davol, Rector Thomson, 195 Lake Ave.
1945 Fisher, Joseph G., Ituri Towers
1937 Gates, Aaron Billings, 305 Millbank Ave.
1942 Halloran, James Vincent, 161 Mason
1937 Hawthorne, Julian, Greenwich Towers
1944 Kelemen, Jeno, Municipal Hospital
1927 Knapp, Charles Stanley, 18 Field Point Rd.
1918 Knapp, Charles Whittemore, 43 Maple Ave.
1916 Knowlton, Donald Jerome, 36 Mason
1940 Larimore, Louise D., 100 Lake Ave.
1933 Lockwood, Jane, 271 Lake Ave.
1932 McCreery, John Alexander, 43 Maple Ave.
1944 *Morrissett, Leslie E., Stanwich Rd.
1924 O'Donnell, Thomas James, 224 Milbank
1939 *Reynolds, Whitman Mead, 53 Mason
1935 *Rogers, Robert Page, 111 North
1938 *Serrell, Howard P., 43 Maple Ave.
1940 Shaw, Lillian Eloise, Ituri Towers
1943 Squier, Raymond R., 40 West Elm
1937 *Thompson, Sidney Attilio, 161 Mason
1940 Tiebout, Harry Morgan, Blythewood
1934 *Tinkess, Donald Ewing, Ituri Towers
1939 *Tunick, George L., 193 Mason
1933 Vickers, James Leonard, 40 West Elm
1942 *Weber, Frederick Clarence, Jr., 40 West Elm

### Cos Cob

1940 *Ayres, Payson Bryan, 10 Old Post Rd.
1912 Bergin, Thomas Joseph, 2 Mead Ave.
1940 Bria, William Francis, 525 East Putnam Ave.
1945 Meeker, David Olan, Stanwich Rd.

### Old Greenwich

1926 Kaprielian, Haigazoon Kruger, 312 South Beach Ave.
1936 *Kelly, James Colman Francis, 282 Sound Beach Ave.
1939 Read, Francis Arnold, 292 Sound Beach Ave.
1929 Shermak, Joseph V., 13 Arcadia Rd.

## MONROE

### Stepney Depot

1912 Wales, Francis Joseph

## NEW CANAAN

1937 *Abrahams, Meyer, 191 South
1942 *Bradley, Edwin Tremain, 28 Elm
1933 Bucciarelli, John Anthony, 93 East Ave.
1939 Cammann, Oswald DeNormandie, 80 South Ave.
1941 Cody, Thomas Patrick, 222 South Main
1938 DuBois, Franklin Smith, Silver Hill
1939 *Frothingham, John Gerrish, 149 South Main
1941 *Hebard, George Whiting, 28 Elm
1945 Hiden, Robert Battaile, Silver Hill
1935 Ludlow, George Craig, 8 Oenoke Ave.
1942 *Robison, Roy Calvin, 245 South Main
1935 Terhune, William Barclay, Silver Hill
1941 *Twachtman, Eric, 201 Park
1931 Wadsworth, Ruth Flanigen, Smith Ridge
1944 White, Ralph L., 178 South Main

## NEWTOWN

1934 Clow, Henry Leon, Fairfield State Hospital
1927 Desmond, Waldo Fairfield, Main
1937 Egee, J. Benton
1941 *Friedman, Samuel, Fairfield State Hospital
1940 *Green, William Frederick, Fairfield State Hospital
1935 Grout, Stillman Proctor, Fairfield State Hospital
1941 *Kennedy, Robert Edward, Fairfield State Hospital
1936 †Moore, Clifford Douglas, Fairfield State Hospital
1941 Oltman, Jane Elizabeth, Fairfield State Hospital
1943 Robey, Nathaniel C., Fairfield State Hospital

## NORWALK

1933 *Chipman, Sidney Shaw, 520 West Ave.
1937 *Diamond, Edward H., 154 East Ave.
1940 Fitzpatrick, Wesley Fenton, 85 East Ave.
1938 Gorham, Grace Viola, 64 Wall
1915 Kellogg, Henry Kirke White, 725 West Ave.
1930 Miller, John, 711 West Ave., and 63 North St., Greenwich
1938 Northrop, Robert Arthur, 64 Wall
1938 Padula, Ralph Domenick, 84 West Ave.
1929 *Patterson, Frederick Arthur, 520 West Ave.
1938 Perdue, Robert E., 625 West Ave.
1930 Perkins, Charles Winfield, 520 West Ave.
1920 Perry, Mabelle Jeane, 676 West Ave.
1938 Piasecki, Joseph L., 520 West Ave.
1939 *Scanlon, John Joseph 276 West Ave.
1928 Scanlon, Thomas Francis, 394 West Ave.
1929 Tracey, Edward John, 637 West Ave.
1890 Tracey, William Joseph, 637 West Ave.
1920 Tracey, William Wallace, 637 West Ave.
1938 Vollmer, John William, 654 West Ave.
1934 *Wallace, Victor George Henry, 463 West Ave. and 1 Atlantic St., Stamford
1938 *Weinstein, Nathan, 463 West Ave.
1943 *Willis, Thayer, Bettswood Rd.
1942 *Yohn, Albert Klamroth, 502 West Ave.

### South Norwalk

1936 †Beck, Eugene Cornelius, 75 South Main
1918 Bradley, Theron Robert, 9 Washington
1941 Cody, George Richard, 61 South Main
1938 Corridon, James Donald, 47 Seaview Ave.
1943 *Davis, James Sumner, 2 Gibson Court
1922 Fawcett, George Gifford, 8 Washington
1941 *Flanagan, Edwin Daniel, 141 West Ave.
1938 Giuliano, Louis Augustine, 84 West Ave.
1941 Green, H. Howard, 75 South Main
1940 Heafey, John Robert, 84 West Ave.
1938 Hunkemeir, Edna, 75 South Main
1941 *McMahon, John David, 3 Washington
1923 McMahon, William Henry, Jr., 13 Washington
1938 Paris, Marcus, 34 West Ave.

1941 Rosenthal, Isidor, 72 South Main
1941 Shain, Joseph H., 76 South Main
1896 Sherer, Henry Clifford, 1 Washington
1931 Simon, Louis Goodwin, 59 South Main
1943 Steinberger, Lazslo, 96 South Main
1937 Stietzel, Eric Ernst, 5 Washington
1939 Zweben, Albert, 74 South Main

## REDDING

1941 Grevatt, Kenneth Lloyd

## RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main
1944 Inkster, James Henry, 153 Main
1927 Woodford, Francis Bowditch, 62 Main

## SHELTON

1945 Burns, Francis Michael, 499 Howe Ave.
1939 Edson, Ralph Howard, 77 Oak Ave.
1917 Finn, Edward James, 452 Howe Ave.
1930 Gaetz, Thomas Harold, Laurel Heights
1937 Howlett, Kirby Smith, Jr., Laurel Heights
1925 Lynch, Edward James, Laurel Heights
1941 *Pagliaro, Joseph John, 476 Howe Ave.
1895 Randall, William Sherman, 241 Coram Ave.

## STAMFORD

1937 *Aldwin, Francis Joseph, 295 Atlantic
1936 *Bannon, Frederick Michael, 65 South
1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium
1927 Bissell, Addison Hayes, 65 South
1944 Blass, Gustaf, Stamford Hall
1926 Bowman, Stuart Howard, 65 South
1928 Brown, Paul Hemingway, 52 South
1935 Carpenter, Robert Morse, 636 Summer
1937 Carwin, Joseph Lucian, Jr., 115 West Main
1944 Cassone, Rocco, 308 Atlantic
1940 Cognetta, James John, 366 Atlantic
1942 Colmers, Rudolph Albert, 295 Atlantic
1940 *Connolly, Joseph Patrick, 79 Warren
1937 Costanzo, James Joseph, 300 Main
1945 *Costanzo, Ralph Edward, 70 St. George Ave.
1940 *Crane, James Everett, 50 Glenbrook Rd.
1909 Crane, Ralph William, 50 Glenbrook Rd.
1937 *Cunningham, Robert D. M., 1 Atlantic
1934 .D'Andrea, Frank Henry, 29 South
1938 †Dean, Stanley Rochelle, 322 Main
1909 Dichter, Charles Levi, 33 Forest
1935 *Dichter, Irving Samuel, 252 West Broad
1937 *Dorion, Robinson Harry, 610 Summer
1933 Fincke, Charles Louis, 1 Atlantic
1937 Fine, Barnet, 70 Grove
1936 *Fine, Joseph, 96 Main
1931 Fiske, Madeline, 77 Bedford
1934 Friedberg, Solomon, 671 Bedford
1931 Gandy, Raymond Alfred, 65 South
1913 Gandy, Raymond Reeves, 65 South
1931 Giles, Newell Walton, 1 Atlantic
1941 *Grady, Joseph Francis, 65 South
1945 Greenblatt, Jacob, 67 Forest
1929 *Hamilton, John Stewart Marshall, 88 South
1937 Harrison, Francis Murphy, 512 Atlantic
1908 Harrison, John Francis, 512 Atlantic
1916 Henderson, Alfred Collard, 55 Glenbrook Rd.
1935 *Henderson, Jean, 25 Bedford
1930 *Hertzberg, Reinhold Frederick, 126 Woodside Village
1937 *Hopper, Edward Bernard, 58 South
1937 *Hymovich, Leo, 74 Park Pl.
1944 *Jaiven, Saul Joseph, 74 West Park Pl.
1929 Keddy, Russell Alfred, Stamford Hospital
1938 Kezel, Albert Patrick C., 449 Atlantic
1939 *Koffler, Arthur, 71 River
1945 Lewis, Frederic, 65 South
1934 Malloy, Edward Francis, 65 South
1933 McFarland, Frederick William, 65 South
1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.
1935 McGourty, David Philip, 70 Strawberry Hill
1924 McMahon, Francis Cash, 62 Suburban Ave.
1930 Meschter, Eugene Funk, Yale & Towne Mfg. Co.
1938 *Murphy, Charles Anthony, 65 South
1931 Murray, Henry Joseph, 53 South
1940 Nemoitin, Bernard Oscar, 96 Main
1911 Nemoitin, Jacob, 96 Main
1928 Paul, Voyle Abrams, 65 South
1938 *Rawls, Edward Cotton, 1 Atlantic
1929 Resnik, William Harry, 65 South
1936 †Rose, Samuel Allison, 65 South
1937 Rowell, Edward Everett, 104 South
1943 Ryder, Clifford Fuller, 77 Bedford
1929 Rynard, William Morvel Wesley, 29 South
1932 *Schmidt, Norman Louis, 29 Wenzel Ter.
1930 *Sette, Alfred Joseph. 308 Atlantic
1938 *Sherman, Saul Harvey, 81 Bedford
1941 Smith, Leo Michael, 65 South
1917 Smith, William Earl, 65 South
1934 *Starrett, Jay Ellis, 885 Summer
1907 Staub, John Howard, 100 South
1931 Stone, Merlin Jones, 76 Glenbrook Rd., also 161 Mason, Greenwich
1920 Stringfield, Oliver Linwood, 1416 Bedford
1940 *Swarts, William B., 1 Atlantic
1940 *Troy, William Daniel, 3 St. George Ave.
1931 Turnley, William Henry, 1 Atlantic
1939 Washburn, Wendell James, 65 South, and 261 Lake Ave., Greenwich
1937 Weaver, Bruce Stevens, P. O. Box 223

### Glenbrook

1942 Cram, George Eversleigh, 1 Elm Pl.
1938 *O'Meara, Francis Patrick, 1 Elm Pl.

### Springdale

1942 *Stankard, William Francis, 833 Hope

## STRATFORD

1938 *Ashcroft, Allan Davis, 3585 Main
1941 *Benton, Philip Eglin, 972 East Broadway
1945 Buda, Gaza Edward, 2362 Main
1943 Dinan, Henry Philip, 3466 Main
1897 Fleck, Harry Willard, 1 Pauline St., Lordship
1936 *Friedman, Nathan Harris, 2336 Main
1927 *Haberlin, Chester Edward, 2921 Main
1929 Hennessey, Edward Henry Joseph, 2390 Main
1939 Levy, Samuel Howard, 3007 Main
1934 Maher, John Rodden, 2184 Main
1931 Oesau, Harold Thomas, 1949 Main
1940 *Penner, Sidney Lincoln, 2692 Main
1942 Roberge, George Edward, 44 Plymouth
1937 Strayer, Estella Morton, Lordship Rd.
1942 Thomases, Saul, 2336 Main

## TRUMBULL

### Long Hill

1912 Smith, George Arthur

WESTPORT

1943 *Berne, Eric L., Westport Sanitarium
1930 †Ellrich, David Lionel, 125 East State
1943 *Gerow, George H., State St.
1943 Hart, J. Garwood, 44 Church Lane
1943 Houze, Harry G., Westport Sanitarium
1941 *Kelsey, Weston Maynard, South Compo Rd.
1934 Morgan, William Oliver, 193 Main
1937 *Nespor, Robert Venzel, 89 Main
1925 *Phillips, Harry Shaw, 44 East Church
1941 Shoup, Homer B., Jr., 58 East State St.
1943 Solway, Reuben Isaac H., 450 Kings Highway
1936 Teuscher, William Philip, 18 Compo Rd.

WILTON

1941 Ingram, Herbert Duncan, Cannon Dale Rd.
1939 Knauth, Marjorie Strauss, Drum Hill Rd.
1944 McCombs, A. Parks, Hurlbutt
1942 Upham, Charles E. H., Ridgefield Rd.
1942 *Wood, Horatio C., 3rd, DeForest Rd.

OUT OF COUNTY

1939 Brewer, Francis, United Aircraft, East Hartford
1937 *Craighill, Margaret D., Women's Medical College of Pennsylvania, Henry Ave. and Abbottsford Rd., Philadelphia, Penn.
1939 Ireland, Richard Milton, 66 Bridge, New Milford
1939 *Keating, John Joseph, 20 South Main, New Milford
1941 †Knepp, James Warren, 476 Main, Worcester, Mass.
1904 MacLean, Donald Robert, 32 Atwater, New Haven
1938 †Mathews, Frank Pelleutreau, Glenacres Farm, Vashon, Washington
1942 Parker, Ralph Layton, Skin and Cancer Hosp., Post Graduate Hosp., New York City
1907 Pratt, Nathan Tolles, Old Saybrook
1941 Reid, Lee Rhodes, Uncas-on-Thames, Norwich
1909 Shirk, Samuel Martin, Masonic Home, Wallingford
1939 *Simses, John Peter, 1147 15th St., N. W., Washington, D. C.
1937 Throckmorton, Verl John, 32 Farmstead Lane, Farmington

## Hartford County Association

*President:* Edward A. Deming, 715 Asylum St., Hartford
*Vice-President:* Aaron P. Pratt, 253 Broad St., East Windsor
*Secretary-Treasurer:* Samuel Donner, 99 Pratt St., Hartford
*Councilor:* D. C. Y. Moore, 689 Main St., South Manchester
*Business Office:* 38 Prospect St., Hartford

Annual Meeting, First Tuesday in April
Semi-Annual Meeting, Fourth Tuesday in October

AVON

1941 Farquhar, Lucille Reed, Main
1941 *Wiepert, William Murray

BERLIN

1908 Hodgson, Thomas Cady, Worthington Ridge

BLOOMFIELD

1936 Burgdorf, Alfred Louis, Duncaster Rd.
1905 Clifton, Harry Coltman, Simsbury Rd.
1905 Swett, Paul Plummer, Gun Mill Rd.

BRISTOL

1930 Appell, Paul Harry, 227 Main
1934 Beatrice, Alphonse Anthony, 331 Main
1936 *Bird, Frederick Stanford, 124 Main
1932 Borkowski, Boleslaus Joseph, 4 School
1900 Brackett, Arthur Stone, 321 Main
1934 Donohue, Bartholomew Francis, 481 North Main
1935 Flynn, William Henry, 9 North Main
1925 Gore, Michael Alvord, 321 Main
1937 Hall, Martin Irving, 269 North Main
1921 Hanrahan, William Richard, 209 Center
1938 *Hudon, Frederick Alfred, 321 Main
1943 *Iannotti, John Pasquale, Bristol Hospital
1939 *Labuz, Eugene Frank, 342 Main
1928 LaPlume, Albert Antonio, 45 Prospect
1942 *Littwin, Ralph J., Bristol Hospital
1929 Nestos, Peter Alexander, 63 Main
1935 *Papa, John Smith, 124 Main
1921 Park, Paul Archibald, 133 Main
1921 Richardson, Ralph Augustus, 4 School
1922 Robbins, Benjamin Bissell, 47 Main
1935 Siliciano, Raoul Andrew Victorius, 110 South
1936 †Stevenson, William Robb, 124 Main
1939 †Tirella, Fred Francis, 249 Main
1942 *Vogel, Siegfried, 288 Main
1909 Whipple, Benedict Nolasco, 45 North Main
1934 *Winters, Hyman W., 405 North Main
1914 Woodward, Harold Burton, 321 Main

CANTON

Collinsville

1906 Cox, Ralph Benjamin

EAST HARTFORD

1931 Brecker, Francis Wellington, 27 Wells Ave.
1936 Gallivan, John Norman, 74 Connecticut Blvd.
1927 Goddard, Harvey Burton, 970 Main
1923 Haylett, Howard Bulkeley, 1109 Main
1933 Houle, Raymond Theodore, 5 Central Ave.
1934 Lublin, Raymond David, 759 Main
1937 *McCue, Martin Patrick, 1429 Main
1939 *Mirabile, Thomas Joseph, 59 Burnside Ave.
1916 Onderdonk, Harrie Jay, 11 Central Ave.
1943 Pharris, Crit, United Aircraft
1942 Pitegoff, Charles Haskell, 1559 Main
1942 *Trantolo, Arthur, 2 Roberts Court

EAST WINDSOR

Broad Brook

1944 Doerr, William John
1923 *Robinson, Wilfred John Thomas, Main

Warehouse Point

1937 Maslak, Rudolph, South Main

ENFIELD

Hazardville

1906 Bridge, John Law, P. O. Box 272
1923 Shepherd, William Gordon, Main

Thompsonville

1937 *Bloom, David Irving, 134 Pearl
1937 Dignam, Bernard Stephen, 133 Pearl
1932 Fancher, Henry Wilson, 1070 Enfield
1938 *Gourlie, Howard Wallace, 53 New King
1941 Kucewicz, William Joseph, 41 Pearl
1932 McHugh, John Francis, 29 Central
1916 Simonton, Frank Forester, 75 North Main
1917 Vail, Thornton Edwin, 124 Main
1940 *Valenski, Thaddeus James, Main

FARMINGTON

1933 Bunnell, Walls Willard, Main
1939 *Ewell, John Woodruff, Farmington
1935 MacLean, Ethel Margaret, High

GLASTONBURY

1933 Earle, Benjamin Baylis, 2458 Main
1935 Griswold, Edwin Monroe, 28 Ripley Rd.
1939 *Raffa, Joseph, 2638 Main
1920 †Schaefer, Jacob
1924 Whittles, Lee Jay, 2205 Main

South Glastonbury

1908 Ward, James W., 972 Main

GRANBY

1923 Pendleton, Ernest Raymond

HARTFORD

1942 *Allen, George Francis, 179 Allyn
1944 Allen, Mary Mazner, 179 Allyn
1927 Allen, Wilmar Mason, 20 South Hudson
1927 Antupit, Louis, 242 Trumbull
1936 *Apter, Harry, 1453 Main
1932 Arons, Milton Robert, 750 Main
1904 Backus, Harold Simeon, 99 Pratt
1934 Bailey, Harry, 242 Trumbull
1913 Bailey, Neil Herbert, 550 Main
1923 Bancroft, Harold Arthur, 179 Allyn
1940 Barker, Norman J., 55 Elm
1943 Barton, Preston Nichols, 17 Van Dyke Ave.
1933 *Bausch, Carl Philipp, 36 Pearl
1886 Beach, Charles Coffing, 54 Woodland
1907 Beach, Charles Thomas, 50 Farmington Ave.
1929 Beatman, Israel, 242 Trumbull
1944 Beebe, John Taylor, 20 South Hudson
1923 Bestor, Eugene Leonard, 36 Pearl
1941 *Bick, John William, Jr., 200 Retreat Ave.
1926 *Bidgood, Charles Young, 179 Allyn
1936 *Bingham, Charles Tiffany, 576 Farmington Ave.
1913 Biram, James Harrington, c/o Colt's Patent Fire Arms Mfg. Company, 17 Van Dyke Ave.
1938 *Birge, Henry L., 179 Allyn
1941 *Bobrow, Aaron, 242 Trumbull
1897 Botsford, Charles Porter, 219 Collins
1942 *Brackin, John Tudor, Jr., 179 Allyn
1941 Brandon, Kenneth Francis, 151 Farmington Ave.
1916 Branon, Anthony William, 179 Allyn
1912 Brayton, Howard Wheaton, 179 Allyn
1939 Brennan, Edward L., 200 Retreat Ave.
1931 *Brewer, Timothy Francis, 50 Farmington Ave.
1943 Browne, Florence A., 550 Main
1942 Bruskin, Chaim Elias, 1840 Park
1929 *Buck, Burdette Jay, 50 Farmington Ave.
1931 Buckley, Richard Cotter, 683 Asylum Ave.
1932 Burlingame, Clarence Charles, 200 Retreat Ave.
1937 Burns, Maudie Marie, 165 Capitol Ave.
1928 Butler, Nicholas George, 50 Farmington Ave.
1930 Byrne, David Walter, 179 Allyn
1942 Cabaniss, Joseph Turner, 700 Main
1934 Cappiello, Silvestro, 97 Vine
1933 Carey, Thomas Cornelius, 50 Farmington Ave.
1931 Carniglia, Ettore Francis, 50 Farmington Ave.
1929 Carroll, James Edward, 220 Farmington Ave.
1915 Carter, Earl Buell, 99 Pratt
1930 Caulfield, Ernest Joseph, 683 Asylum Ave.
1933 *Cenci, Vincent Peter, 242 Trumbull
1940 †Clancy, John James, 179 Allyn
1935 Clarke, Ralph deBallard, Cedarcrest
1922 Clason, Freeman Pell, 179 Allyn
1937 Clifford, Martha Louise, 165 Capitol Ave.
1931 Climan, Max, 242 Trumbull
1928 Cogan, George Eugene, 50 Farmington Ave.
1940 *Cogland, John Lee, 550 Main
1913 Cogswell, Eliot Sanborn, 179 Allyn
1936 Cogswell, Lawrence Perley, Underwood Elliot Fisher Co.
1938 *Cohn, Samuel Hills, 235 Cornwall
1935 Connor, Joseph Joyce, 750 Main
1933 Corcoran, Michael Anthony, 689 Asylum Ave.
1913 Costello, Henry Nicholas, 134 Beacon
1921 Cragin, Donald Brett, 151 Farmington Ave.
1933 *Crosby, Edward Harding, 50 Farmington Ave.
1941 *Cullen, James Rescott, 50 Farmington Ave.
1936 Cunningham, James Morrow, 165 Capitol Ave.
1938 *Curtis, Burr Harding, 4 Atwood
1914 Daly, Charles William, 750 Main
1935 Daly, William Patrick, 342 Edgewood
1929 Davenport, Anna Keith Prentiss, 50 Wethersfield Ave.
1922 Davis, James Edward, 16 Sunny Reach Dr.
1932 Dawson, Lionel Montrose, 700 Main
1909 DeBonis, Domencio A., 183 Westland
1914 Deming, Clinton Demas, 179 Allyn
1914 Deming, Edward Adams, 715 Asylum Ave.
1931 *DePasquale Francis Lawrence, 380 Campfield Ave.
1937 *DePasquale, John Anthony, 381 West Preston
1934 DeVito, Michael Joseph, 525 Main
1930 Dignam, Edward Anthony, 750 Main
1921 Dinsmore, William Wirt, 700 Main
1931 *Dion, Asa Joseph, 207 Washington
1944 Dion, Julien Andre, 207 Washington
1939 *Dodd, Burwell, 689 Asylum
1934 Donner, Samuel, 99 Pratt
1938 Donovan, William Francis, 47 Main
1937 *Duffy, Leo Thomas, 18 Chaplin Pl.
1942 Duksa, Walter Joseph, 535 Main
1923 Dunne, Richard Edwin, 30 Farmington Ave.
1938 *Durkee, Ralph Everett, Jr., 179 Allyn
1916 Dwyer, William, 18 Asylum
1942 Edson, Reginald Campbell, 165 Capitol Ave.
1927 Elliot, K. Gregory, 631 Park
1943 Ellis, Lyle Gaffney, 700 Main
1937 Ellison, Frederick Speirs, 50 Farmington Ave.
1895 Elmer, Edward Oliver, 1731 Park
1914 Emmett, Francis Arthur, 410 Asylum
1933 Farland, Victor Louis, 54 Pratt
1919 Fay, William James, 179 Allyn
1941 *Feeney, Thomas Michael, 61 Evergreen Ave.
1929 Felty, Augustus R., 50 Farmington Ave.
1942 Finesilver, Edward Max, 410 Asylum
1934 Finley, George Clark, 50 Farmington Ave.
1913 Flaherty. Claude Vincent, 50 Farmington Ave.
1943 Fleish, Milton Art, 2 Holcomb
1943 Fox, George Francis, 27 Allendale Rd.
1931 Friery, Clarence Milton, 110 Greenfield
1943 Fritz, John, 656 Park
1919 Furniss, Henry Watson, 1337 Main
1927 Gaberman, David, 179 Allyn
1937 Galinsky, David, 780 Wethersfield Ave.
1921 Garland, Robert Bernard, 689 Asylum Ave.
1941 Gibson, Forrest Davis, 50 Farmington Ave.
1898 Gill, Michael Henry, 36 Pearl
1941 *Gillespie, Harry, 983 Main
1922 Gills, William Lee, 179 Allyn
1934 Giorgio, Nicholas Anthony, 61 Edwards
1937 Giuliano, Sebastian, 468 Franklin Ave.
1935 Glass, George Courtenay, 576 Farmington Ave.
1943 †Glass, William Henry, 11 Asylum

1934 Glaubman, Henry Mitchell, 20 Lenox
1927 Goff, Charles Weer, 30 Farmington Ave.
1936 Gold, Louis Henry, 184 North Beacon
1930 Goldenberg, Jacob Joseph, 832 Albany Ave.
1944 Golston, Harry, 750 Main
1933 *Goodell, Robert Alvan, 79 Elm
1900 Goodrich, Charles Augustus, 5 Haynes
1919 Gosselin, George Adelor, 50 Farmington Ave.
1935 Gould, Max Martin, 434 Main
1923 Grau, Leroy Charles, 700 Main
1938 Gray, Harry Joshua, 750 Main
1924 Griswold, Matthew Hammond, 165 Capitol Ave.
1941 Grossman, Walter, 242 Trumbull
1921 Grosvenor, Frank Livingston, 700 Main
1941 *Gudger, James Roby, 140 Garden
1930 Hall, Llewellyn, 79 Elm
1939 †Hall, Wendell Charles, 179 Allyn
1938 *Harris, Louis David, 242 Trumbull
1936 Harvey, Daniel Foster, 218 North Beacon
1930 Hastings, Louis Pease, 114 Woodland
1931 †Hennessy, James Joseph, 50 Farmington Ave.
1907 Hepburn, Thomas Norval, 179 Allyn
1940 *Heublein, Gilbert Whipple, 179 Allyn
1930 Heyman, Joseph, 650 Main
1941 Hickcox, Curtis Bronson, 20 South Hudson
1934 Hirschfeld, Otto Max, 1037 Albany Ave.
1931 Hirshberg, Manuel Shelton, 135 Blue Hills Ave.
1925 Hoffman, Charles Curtis, 700 Main
1924 Hogan, Walter Louis, 750 Main
1929 Holt, Kerchival Rogers, 50 Farmington Ave.
1930 Holtz, Raymond Sidney, 7 Woodland
1945 Hopper, Jerome Murray, 50 Farmington Ave.
1935 *Hough, Perry Tyler, 178 Beacon
1922 Howe, Glover Elbridge, 576 Farmington Ave.
1936 *Hurwitz, George Hillel, 75 Pearl
1920 Hurwitz, Herman Max, 75 Pearl
1917 Hutchison, James Elder, 125 Trumbull
1937 *Irving, James Grant, 151 Farmington Ave.
1939 Jackson, Allen Francis, 2137 Main
1944 Jacobson, Charles Edward, Jr., 50 Farmington
1934 *James, Lewis Paul, 68 Pratt
1941 *January, Derick Algernon, 111 Gillett
1942 January, Mildred Hartshorn, 111 Gillett
1912 Jarvis, Henry Gildersleeve, 179 Allyn
1940 *Jenovese, Joseph Francis, 280 Collins
1941 †Johnson, Paul, 179 Allyn
1930 Jones, Frank Stafford, 179 Allyn
1928 Kalin, Jacob Isaac, 725 Asylum Ave.
1933 Kardys, John Albert, 487 Main
1935 Karotkin, Robert Harold, 816 Albany Ave.
1935 Kaschmann, Joseph, 42 Asylum
1937 Katz, Dewey, 99 Pratt
1924 Katz, Henry, 750 Main
1941 Katzman, Samuel Sidney, 11 Asylum
1926 Keefe, George Gregory, 30 Sisson Ave.
1934 Keefe, Raymond Starkey, 272 Franklin Ave.
1934 *Keefe, Walter Joseph. 30 Sisson Ave.
1908 Keith, Albert Russell, 50 Farmington Ave.
1920 Kelly, Claude Currie, 179 Allyn
1930 Kendall, Ralph Emerson, 20 South Hudson
1927 Kilbourn, Austin, 1039 Asylum Ave.
1920 Kilbourn, Joseph Birney, 36 Pearl
1906 Kingsbury, Isaac William, 125 Trumbull
1932 Klein, Abraham Arthur, 509 Farmington Ave.
1925 Knowlton, Millard, 165 Capitol Ave.
1944 Krall, Irving Hadley, 99 Pratt
1930 Kunkel, Frederick Earle, 179 Allyn
1941 Lamoureux, Eugene Edward 165 Capitol Ave.
1901 Lampson, Edward Rutledge, 175 North Beacon
1938 *Lampson, Rutledge Starr, 179 Allyn
1913 Landry, Arthur Bernard, 50 Farmington Ave.
1926 Landry, Benedict Bernard, 50 Farmington Ave.
1940 *Lankin, Joseph John, 525 Main
1943 *Lapenta, Rocco George, 1307 Albany Ave.
1929 Larrabee, John Whitfield, 650 Main
1942 Leary, Deborah Cushing, 179 Allyn
1942 Lenehan, John Richard, 683 Asylum Ave.
1933 Levin, Albert Eliot, 242 Trumbull
1942 Levin, Charles Alec, 854 Asylum Ave.
1935 Levine, Sinclair Simcha, 54 Church
1937 Lischner, Moses David, 75 Pearl
1934 Little, Milton Frederick, 49 Pearl
1915 Locke, Harry Leslie Franklin, 179 Allyn
1941 *Lowell, William Holbrook, Jr., 580 Asylum
1923 Luby, Thomas John, 410 Asylum
1913 Madden, Leon Irving, 50 Farmington Ave.
1919 Maislen, Samuel, 2138 Main
1931 Mancoll, Morris Max, 242 Trumbull
1943 Marinaro, Nicholas Anthony, Cedarcrest
1932 Marranzini, Samuel, 763 Albany Ave.
1930 McClellan, Wilbert Ernest, 75 Pearl
1898 McCook, John Butler, 390 Main
1936 McCormack, Christopher Joseph, 50 Farmington Ave.
1938 *McCrann, Donald Joseph, 50 Farmington Ave.
1934 McDermott, John Francis, 750 Main
1933 McGrath, John Francis, 663 Maple Ave.
1934 McLean, John Joseph, 650 Main
1932 *McLellan, Philip Garretson, 683 Asylum Ave.
1935 *McNulty, Terence Francis, 21 Sisson Ave.
1916 McPherson, Sidney Horace, 4 Atwood
1933 *Middlebrook, Louis Francis, Jr., 689 Asylum Ave.
1916 Miller, James Raglan, 179 Allyn
1933 Mirabile, Charles Samuel, 179 Allyn
1944 Moise, Theodore Sidney, 151 Farmington Ave.
1938 *Montano, Charles Carl, 525 Main
1937 *Montano, Rocco Anthony, 242 Trumbull
1909 Morrissey, Michael Joseph, 18 Asylum
1929 Morse, Lyman Rogers, Cedarcrest
1939 *Moxness, Bennie Arthur, 165 Capitol Ave.
1927 Moylan, Thomas Patrick, 50 Farmington Ave.
1930 Moyle, Henry Brown, 79 Farmington Ave.
1942 *Mulville, Maurice Francis, 214 Franklin Ave.
1935 *Murphy, Thomas Francis, 619 Park
1897 Naylor, James Henry, 1 Main
1938 *Neidlinger, William James, 576 Farmington Ave.
1944 Nyboer, Jan, 140 Garden
1942 *O'Brien, Henry Rust, 165 Capitol Ave.
1944 O'Connell, John Daniel, 50 Farmington Ave.
1923 O'Connell, John Francis, 865 Park
1928 O'Connell, Maurice Francis, 50 Farmington Ave.
1902 O'Flaherty, Ellen Pembroke, 140 Main
1928 Ogden, Ralph Trafton, 179 Allyn
1931 Olmstead, John Gerald Maurice, 404 Farmington Ave.
1937 O'Neil, Charles William, 18 Asylum
1921 Osborn, Stanley Hart, 165 Capitol Ave.
1927 Osmond, Robert Hunter, 50 Farmington Ave.
1938 †Padula, Vincent Domenica, 1210 Broad
1919 Parker, John Woodcock, 84 Forest
1926 Partridge, Winthrop Prescott, 403 Farmington Ave.
1938 *Peacock, Albert Upham, 576 Farmington Ave.
1944 *Perkins, Joseph Augustine, 404 Prospect Ave.
1933 Phelps, Maxwell Overlock, 576 Farmington Ave.
1937 Phelps, Paul Stetson, State Tuberculosis Commission, 165 Capitol Ave.
1929 *Pike, Maurice Mitchell, 179 Allyn
1944 Pitegoff, Gerald Irving, 242 Trumbull
1943 *Preston, Thomas Raymond, 133 North Quaker Lane
1934 Priddy, Foster Eugene, 30 Farmington Ave.

1936 Quarrier, Sidney Sayre, 576 Farmington Ave.
1923 Radin, Morris Jacob, 36 Pearl
1928 Radom, Myron Michael, 242 Trumbull
1923 Rankin, Bertrand Fred, 57 Pratt
1913 Reardon, William Francis, 750 Main
1934 Reidy, David Dillon, 750 Main
1927 Resnisky, Andrew Francis, 57 Pratt
1928 Reynolds, Harry St. Clair, 410 Asylum
1916 Reynolds, Harry Stephen, 18 Asylum
1930 Reynolds, Robert Gardner, 179 Allyn
1922 Roberts, Douglas James, 179 Allyn
1932 Robinson, Albert James, 55 Elm
1943 Rocco, Mario P., 1125 New Britain Ave.
1940 Roche, Arthur F., 50 Farmington Ave.
1934 Rollins, Henry Brock, 140 Garden
1932 *Romaniello, Rocco John, 415 Hillside Ave.
1909 Rooney, James Francis, 410 Asylum
1936 *Rosenbaum, George Jonas, 647 New Britain Ave.
1938 Rosenthal, Ernest, 18 Asylum
1935 Roth, Frank Edward, 650 Main
1907 Rowley, Robert Lee, 79 Elm
1921 Russell, George Gardiner, 179 Allyn
1923 St. John, Leopold Albert, 25 Charter Oak Ave.
1926 Salvin, Benjamin Lloyd, 242 Trumbull
1932 *Samponaro, Nicholas, 650 Main
1937 *Sayers, John Joseph, 656 Park
1928 Scafarello, Peter Joseph, 410 Asylum
1932 Schaefer, Abraham Maurice, 262 Maple Ave.
1934 Schuman, David Harold, 909 Albany Ave.
1940 *Scoville, William Beecher, 179 Allyn
1932 *Seibert, Alfred Frank, 700 Main
1942 Serbin, Aaron Frederick, 99 Pratt
1920 Shafer, Alexander Samuel, 68 Pratt
1928 Shaw, George Hammil, 700 Main
1920 Shea, Daniel Edward, 137 North Whitney
1944 Shepard, Marguerite Dunbar, Cedarcrest
1941 †Shull, John Coulter, 179 Allyn
1933 *Shulman, David Nathaniel, 422 Farmington Ave.
1940 *Shupis, Anthony, Jr., 444 Park
1932 Sigal, Jacob Bernard, 99 Pratt
1936 *Slossburg, David Seymour, 541 Park
1942 Smith, Hugh Allen, 179 Allyn
1944 Smith, Percy Lawson, 200 Retreat Ave.
1944 Smith, William Leslie, 179 Allyn
1939 *Smith, Wilson Fitch, 576 Farmington Ave.
1937 *Sneidman, George Irving, 18 Asylum
1929 Snelling, Pinckney Welch, 179 Allyn
1944 *Solomkin, Mark, 708 Garden
1937 Spekter, Louis, 165 Capitol Ave.
1921 Spillane, Bernard, 30 Farmington Ave.
1941 *Sponzo, James Joseph, 3 Webster
1927 Standish, Erland Myles, 179 Allyn
1897 Standish, James Herbert, 30 Farmington Ave.
1931 *Standish, Welles Adams, 665 Asylum Ave.
1905 Starr, Robert Sythoff, 179 Allyn
1930 Steincrohn, Peter Joseph, 705 Asylum Ave.
1923 Storrs, Ralph Warren, 179 Allyn
1907 Swan, Horace Cheney, Trinity College
1914 Sweet, John Henry Throop, Jr., 179 Allyn
1932 Talbot, Henry Pierce, 165 Capitol Ave.
1930 *Taylor, Andrew, 179 Allyn
1906 Taylor, Maude Winifred, 914 Asylum Ave.
1939 Tennant, Robert, 20 South Hudson
1922 Thompson, Hartwell Greene, 179 Allyn
1938 *Tonken, Louis Clarence, 485 Farmington Ave.
1938 *Tovell, Ralph Moore, 20 South Hudson
1930 *Townsend, Wilmot Charles, 50 Farmington Ave.
1912 Truex, Edward Hamilton, 99 Pratt
1942 *Truex, Edward Hamilton, Jr., 99 Pratt
1908 Tuch, Morris, 99 Pratt
1907 Turbert, Edward Joseph, 703 Asylum Ave.
1937 *Unsworth, Arthur Charles, 179 Allyn
1933 Uricchio, Joseph George, 260 Wethersfield Ave.
1908 Vail, George Francis, 36 Pearl
1923 VanKleeck, Euen, 700 Main
1904 VanStrander, William Harold, 179 Church
1926 VanWart, William Haley, 650 Main
1917 Vernlund, Carl Frithiof, 179 Allyn
1921 Vershbow, Nathan, 28 Sisson Ave.
1914 Waite, Robert Lester, 68 Pratt
1932 Wallace, Charles Kenneth, 700 Main
1932 Warring, Howard Lewis, 1756 Main
1934 Weiner, Julius Gills, 750 Main
1943 Weiner, Sylvia, 242 Trumbull
1943 Weiner, William, St. Francis Hospital
1931 *Weisenfeld, Nathan, 608 Blue Hills Ave.
1936 Weissenborn, Walter, 50 Farmington Ave.
1920 Weld, Stanley Burnham, 179 Allyn
1916 Wells, Donald Breckinridge, 580 Asylum
1943 Wells, Elizabeth C., 165 Capitol Ave.
1924 Whalen, Edward Joseph, 750 Main
1938 *Whitcomb, Benjamin Bradford, 179 Allyn
1938 *White, Benjamin Vroom, 179 Allyn
1942 Whiting, Richard Charles, 700 Main
1933 Whitty, Charles Aloysius, Cedarcrest
1907 Wiedman, Otto George, 179 Allyn
1931 Wienski, John Casimer, 502 Park
1930 *Wilson, William Augustus, 683 Asylum Ave.
1941 Wineck, Morris Samuel, 179 Allyn
1904 Witter, Orin Russell, 179 Allyn
1933 Wood, Frank Oliver, 576 Farmington Ave.
1934 Woodford, Chester North, 703 Asylum Ave.
1916 Worthen, Thacher Washburn, 179 Allyn
1922 Wright, William Witter, 700 Main
1932 Wulp, George Adolf, 50 Farmington Ave.
1912 Yergason, Robert Moseley, 50 Farmington Ave.
1938 Young, William Greenhill, 200 Retreat Ave.
1928 *Zariphes, Constantinte Argyros Paleslogos, 96 Main
1934 Zeman, Burnhardt, 983 Main

## MANCHESTER

1924 Boyd, Howard, 935 Main
1939 *Conlon, William Linas, 15 Main
1940 *Diskan, Albert Elmer, 869 Main
1936 *Keeney, Robert Raymond, Jr., 791 Main
1925 Knapp, Robert Phineas, 146 Hartford Rd.
1941 Segal, Jacob A., 647 Main
1937 *Sundquist, Alfred Bernhardt, 843 Main
1943 Yerbury, Charles Calvin, 829 Main
1936 *Zaglio, Edmond Robert, 63 Lakewood Circle

### South Manchester

1926 Caldwell, David Manchester, 935 Main
1926 Friend, Amos Edgar, 935 Main
1921 Lundberg, George Albin Ferdinand, 755 Main
1916 Moore, Demarquis DeCasso Ye Rujo, 689 Main
1930 Moriarty, Mortimer Emmett, 905 Main

## NEW BRITAIN

1932 Benoit, Raoul Joseph, 51 Cedar
1934 *Bernstein, Dwight J., 55 West Main
1930 Blogoslawski, Walter Joseph, 199 West Main
1909 Bodley, George Houghton, 155 West Main
1935 Bristoll, Donald Andrews, 55 West Main
1940 *Buccheri, Francis Salvatore, 419 Main
1927 Buol, Robert Stanley, 99 West Main
1935 Chalmers, Harriet Elizabeth, 45 Walnut
1926 Chernaik, Samuel Julius, 300 Main

1943 *Chester, Lewis L., 29 Camp
1913 Cooley, Clifton Mather, 44 South High
1939 Daley, Louis William, 99 West Main
1938 Dalton, George Henry, 99 West Main
1931 Darrow, John Edward, 55 West Main
1928 Donnelly, Stephen Patrick, 55 West Main
1941 Dorian, George David, 300 Main
1941 *Dorian, Neshon Edward, 300 Main
1934 Dray, Edward Joseph, 259 Main
1915 Dunn, George Washington, 55 West Main
1942 Eisenberg, Sidney Edwin, 55 West Main
1933 Ellis, Francis Duffy, Jr., 32 Cedar
1936 Enander, Fred Conrad, 25 Arch
1922 Flanagan, William Francis, 55 West Main
1931 *Geetter, Isadore Stolper, 92 Grand
1941 *Goldschmidt, Myer, 300 Main
1921 Grant, Arthur Sheldon, 55 West Main
1943 Greenblatt, Harold Joseph, 99 West Main
1937 Hart, Carl Jay, 259 Main
1930 Kalett, Joseph, 55 West Main
1924 Kinsella, Michael Allen, 52 Main
1942 *Kraszewski, Henry Walter, 55 West Main
1942 *Lacava, John James, 300 Main
1926 Lekston, Roman Francis, 197 West Main
1938 †LoVetere, Angelo Arthur, 29 Park Pl.
1930 Matteis, Joseph Theodore, 55 West Main
1939 *McMahon, George William, 272 Main
1934 *Michalowski, Valerian Stanislaus, 489 Main
1937 *Miller, Harry Bernard, 81 West Main
1935 Moorad, Philip Jacob, 55 West Main
1923 Mouradian, Marion Garoudy, 87 Prospect
1940 *Nevulis, Anthony Victor, 140 Main
1938 Orbach, Egmont Julius, 81 West Main
1939 Paolillo, Charles Gerald, 55 West Main
1938 *Parlato, Harry Anthony, 55 West Main
1944 Peck, Bernard Carl, 32 Park Pl.
1938 *Perakos, George Peter, 300 Main
1939 *Pola, William Edward, 99 West Main
1930 *Pullen, Richard Woollard, 55 West Main
1936 Resnik, Edward, 272 Main
1940 Rosahn, Paul Dolin, New Britain Hospital
1930 Schechtman, Charles Theodore, 81 West Main
1931 Schupack, Samuel David, 99 West Main
1938 *Scully, Roger Tehan, 136 Kensington
1930 Slysz, Ladislaus Bernard, 247 West Main
1928 Smith, Vincent Joseph, 55 West Main
1936 Squillacote, Vincent Joseph, 55 West Main
1938 Sullivan, Charles Noyes, 55 West Main
1940 Tisher, Paul Winslow, 99 West Main
1935 Tokarczyk, John Joseph, 32 North
1941 *Trapp, Francis W., 55 West Main
1928 Waskowitz, David, 81 West Main
1934 *Watson, William James, 272 Main
1932 *White, John Cowles, New Britain Hospital
1945 Zwick, Frank, 35 South High

NEWINGTON

1942 Freeman, John Jay, 1100 Main
1934 †Sills, Theodore Hopkins, 897 Main

PLAINVILLE

1878 Bull, John Norris, 57 Whiting
1931 Cook, George Francis, 4 East Main
1931 Frost, Lawrence Hubbard, 98 West Main
1934 *Menousek, Joseph Albert, 14 East Main
1938 Tortolani, Aresto Peter, 75 East Main

PLANTSVILLE

1937 Connor, George Michael, 772 South Main

ROCKY HILL

1943 *Greene, Gerald Gabriel, Veterans Hospital
1940 Kelley, Newell Raymond, 23 Riverview Rd.
1904 Moser, Oran Alexander, Elm
1937 *Twaddle, Paul Holmes, 7 Elm

SIMSBURY

1941 *Fuller, Roger Holden, Post Office Bldg.
1925 Murphy, Owen Lee, Weatogue
1932 Stretch, James Edison, Hopmeadow

SOUTHINGTON

1935 Dudac, Thomas William, 9 Center
1933 Gura, George Michael, 22 Main
1935 Nagle, William Thomas, 23 Woodruff
1929 Simmons, Eric Melville, 93 Main
1929 Thalberg, Reuben Edward, 32 North Main

SUFFIELD

1938 *Coates, Stephen Paul, 328 Main
1929 Levy, William, 339 Main
1930 Upson, William Hart, 172 Main

UNIONVILLE

1937 Dunne, Edward Patrick, Main
1941 O'Connell, Enos Joseph, 60 Main

WEST HARTFORD

1937 *Andrews, Egbert Morrill, 18 Four Mile Rd.
1903 Brainard, Clifford Brewster, 10 Mountain View Dr.
1942 Canby, Joseph Edward, Pratt & Whitney Co.
1931 *Case, Edward Percy, 28 Brunswick Ave.
1896 Cochran, Levi Bennett, 15 Golf Rd.
1932 Crawley, George Andrew, 330 Park Rd.
1928 Cushman, Laurence Arnold, 23 South Main
1910 Denne, Thomas Harmon, 39 North Main
1932 Filson, Ralph Marshall, 54 Crestwood Rd.
1926 Glazier, J. Raymond, 26 Sequin Rd.
1939 Gray, Albert Stanley, 1271 Farmington Ave.
1930 Griggs, John Bolter, 42 Middlefield Dr.
1913 Harrington, Amos Thomson, 31 Foxcroft Rd.
1937 *Hazen, Donald Robert, 20 Chelsea Lane
1939 *Hollinshead, Joseph Bentley, 1018 Farmington Ave.
1944 Klein, Rose Herchman, 58 Flagg Rd.
1920 Leak, Roy Lathen, 363 Ridgewood Rd.
1932 *Lundborg, Francis Ludwig, 31 North Main
1935 *Martin, John Garthwaite, 7 South Main
1943 McPartland, Charles E., Town Hall
1939 *Murphy, Thomas Denis, 957 Farmington Ave.
1930 *Parshley, Philip Ford, 20 South Quaker Lane
1937 *Rogers, Frederick Peckham, 11 Ballard Dr.
1924 Root, Maurice Timothy, 51 North Main
1935 Root, Sophie Andrews, 51 North Main
1910 Rowley, John Carter, 17 Colony Rd.
1901 Smith, Earl Terry, Sunset Farm
1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farm
1936 *Stewart, Lester Quentin, 69 South Main
1941 *Sullivan, Arthur Bland, 15 Bainbridge Rd.
1937 *Tait, Arthur Alfred, 333 Park Rd.
1921 Thenebe, Carl Leonard, 720 Farmington Ave.
1937 Walton, Loftus Linwood, 797 Farmington Ave.
1942 Wells, Jean, 1018 Farmington Ave.
1922 Wentworth, John Alexander, 74 Mohawk Dr.
1943 *Wilson, Archibald Cameron, 892 Farmington Ave.
1934 *Winters, John Thomas, 3 South Main

ELMWOOD

1936 †Lewis, Samuel Donald, 536 South Quaker Lane
1941 Sewall, Sydney, 1170 New Britain Ave.

WETHERSFIELD

1938 *Carvey, Edward Vincent, 121 Broad
1933 Howard, Harold Amasa, 330 Main
1927 *Smith, William Bowers, 91 Center
1935 Stempa, Henry, 504 Wolcott Hill Rd.
1932 Storms, William Frederick, 147 Main
1940 Warren, Henry Stanley, 184 Main

WINDSOR

1930 MacCready, William Harold, 38 Elm
1939 *Monacella, John Manilla, 18 Elm
1924 Pratt, Aaron Paul, 253 Broad

WINSDOR LOCKS

1921 Coyle, Anna Elizabeth Mulheron, 16 Church
1937 Coyle, Bruce James, 2 Chestnut

OUT OF COUNTY

1935 Angus, Leslie Robert, The Bancroft School, Haddonfield, New Jersey
1934 Beizer, Edmund, Queens County Hospital, New York City
1931 Calverly, Eleanor Jane Taylor, American University, Cairo, Egypt
1911 Cobb, Albert Edward, Canaan
1937 *Fagan, Francis Xavier, 35 Herkimer, Waterbury
1934 Horning, Benjamin Graham, W. W. Kellogg Foundation, Battle Creek
1943 *Humpage, Norbert W., Winsted
1938 Leonard, John Charles, 12 Arlington Rd., Melrose, Mass.
1928 Mahoney, Daniel F. C., 821 Crescent Ave., Redlands, Calif.
1939 *Phillips, Paul Lange, Dispensary, Norfolk, Va.
1902 Purinton, Charles Oscar, U. S. Veterans Hospital, Sunmount, N. Y.
1936 Ryan, Francis James, Veterans' Administration, Ft. Howard, Md.
1940 *Silver, Gershon Benjamin, Fort Wright, L. I., N. Y.
1930 Stephenson, Charles Wattles, Kennedy General Hospital, Memphis, Tenn.
1923 Walker, William Hastings, Newtown
1942 *Weigle, Luther Alan, Jr., 142 Cold Spring, New Haven

## Litchfield County Association

*President:* Donald W. Herman, 486 Main St., Winsted
*Vice-President:* W. Bradford Walker, Cornwall
*Secretary-Treasurer:* Thomas J. Danaher, 106 Litchfield St., Torrington
*Councilor:* Floyd A. Weed, 199 Main St., Torrington

Annual Meeting, Fourth Tuesday in April
Semi-Annual Meeting, First Tuesday in October

CORNWALL

1940 *Walker, Robert
1922 Walker, Wilmarth Bradford

Cornwall Bridge

1931 Evarts, Josephine, Warren Rd.

LITCHFIELD

1921 Childs, Albert Ewing, West
1935 Kilgus, John Frank, Jr., 80 West
1910 Turkington, Charles Henry, On-the-Green
1896 Warner, Charles Norton, North
1939 Warner, Charles Norton, Jr., North
1936 *Wray, Edward Halloway, Jr., Torrington Rd.

NEW HARTFORD

1942 Markwald, Heinz Wolfgang, Steele Rd.

NEW MILFORD

1938 Stevens, Howard Granson

NORFOLK

1937 Barstow, Richard Iddings, The Village Green
1934 Ursone, Frank Domenico, Greenwoods Rd., W.

NORTH CANAAN

Canaan

1929 Adam, Forbes Sampson
1935 Elliott, John Richard
1924 Sellew, Robert Cowan
1938 *Sellew, Richard Cowan, Jr.

PLYMOUTH

Terryville

1913 Lawton, Richard John, 9 North Main
1939 Wilcox, Lloyd Mather, 19 Maple

SALISBURY

Lakeville

1943 Mackay, William D.
1923 Peterson, Clark Kimball
1936 Wieler, Harry Julius, Hotchkiss School

SHARON

1904 Chaffee, Jerome Stuart, Sharon Hospital
1942 Gudernatch, Gert Steuerwald

THOMASTON

1938 Atha, Henry George, 147 Elm
1903 Hazen, Robert, 45 Union
1910 Kane, James Hugh, 205 South Main
1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

1937 Bienkowski, Joseph George, 24 Church
1898 Carlin, Charles Henry, 236 Main
1930 Danaher, Thomas Joseph, 106 Litchfield
1938 Dobbs, William G. H., 24 Church
1935 Garston, Louis Edward, 49 Main
1931 Giobbe, Michael Edward, 24 East Main
1936 Goldberg, Isadore Solomon, 5 Water
1908 Hanchett, Harry Bigelow, 51 Main
1936 Hill, Emerson Stanley, 51 Main
1941 *Hubert, Gilbert Richard, 24 Church
1917 †Kennedy, William Clement, 309 Litchfield
1938 †Kott, Joseph Henry, 18 Pearl
1936 LoRusso, Domenico Leonardo, 40 Main
1938 *Murcko, William John, 497 Main
1923 Oelschlegel, Herbert Charles, 19 Maiden Lane
1923 Polito, Frank Leonard, 24 Church
1887 Pratt, Elias, 27 Daycoeton Pl.
1942 Riendeau, Fernand Maurice, 30 Mason
1942 Riendeau, Pauline Laure, 30 Mason
1936 *Sutherland, Francis Alexander, 24 Mason
1917 Thomson, Thomas Leonard, 24 Mason
1898 Wadhams, Sanford Hosea, 908 Main
1942 Wallach, Gert M. K., 91 Church
1917 Weed, Floyd Albert, 199 Main

WASHINGTON

1927 Jackson, Arthur Hartt
1908 Wersebe, Frederic William

WATERTOWN

1936 Cleary, Harold John, Main
1897 Loveland, Ernest Kilborn, 48 North
1922 Martin, James Smith
1936 *Meyers, Royal Abbott, 162 Main
1919 Reade, Edwin Godwin, 429 Main

WINCHESTER
Winsted

1945 Ashley, Homer Champion, 384 Main
1938 *Baker, Philip George, 384 Main
1936 *Cornelio, Francis Joseph, 153 Main
1933 Derwin, James Joseph, 350 Main
1915 English, Chester Ferrin, 64 Main
1937 *Gallo, Francis, 384 Main
1927 Herman, Donald Warner, 486 Main
1936 *Levy, Aaron, 384 Main
1912 Reidy, Maurice Joseph, 350 Main
1922 *Sanderson, Roy Voter, 570 Main

WOODBURY

1913 Allen, Howard Sanford
1944 Gillette, Arthur Taylor, Main

NORTH WOODBURY

1940 *Markle, Raymond Dunsmore, Pleasant

OUT OF COUNTY

1942 Downs, Elinor Fosdick, 606 West 122 St., New York City
1938 Ignace, Stephen James, 17 Elizabeth St., Derby
1939 *La Taif, C. George, 96 Park Ave., Danbury
1938 *Orlowski, Andrew Williams, 115 Brooklyn, Rockville
1881 Platt, William Logan, State Hospital, Newtown
1943 Herrick, Francis Leach, Grace Hospital, New Haven

## Middlesex County Association

*President:* Chester Waterman, 119 Main St., Middletown
*Vice-President:* Charles Russman, Box 361, Middletown
*Secretary:* Frank H. Couch, Cromwell Hall, Cromwell
*Councilor:* Harold E. Speight, 642 Main St., Middletown

Annual Meeting, Second Thursday in April
Semi-Annual Meeting, Second Thursday in October

CHESTER

1941 Callender, Eugene Frederick, Drawer F
1935 *Lieberman, David Leonard
1942 Owen, Philip Stanley, Parker's Pt.

CLINTON

1937 *Rindge, Norman Pember, 20 Commerce
1935 Stone, Harry Russell, 67 West Main

CROMWELL

1934 Couch, Frank Hallock, Cromwell Hall
1934 Couch, Mildred Warden, Cromwell Hall
1940 Grant, Richard Francis, 221 Main
1928 Nelson, Walter Nathaniel, 76 Main
1925 Pierson, Emily Miller, 107 Main

DURHAM

1940 Sherwood, Henry, Main

EAST HADDAM

1935 Horsefield, Thomas Earl, P. O. Box 40

EAST HAMPTON

1936 Gardner, Norman Homer
1934 Soreff, Louis, 15 Main

ESSEX

1942 Ames, William Gard
1903 Bradeen, Frederick Barton, P. O. Box No. 221
1942 *Hansen, Paul Scott, King's Corner

MIDDLETOWN

1942 *Apuzzo, Anthony Albert, Connecticut State Hospital
1933 *Beauchemin, Joseph Adelard, Connecticut State Hospital
1944 Bixby, Harriet, Connecticut State Hospital
1941 *Buckley, Willard Emrich, Middlesex Hospital
1937 *Calhoun, Hazen Albert, Jr., 647 Main
1926 Chase, Carl Clarence, 121 Main
1928 Compson, Florence Eberly Mentzer, Connecticut State Hospital
1924 Craig, George Mansfield, 119 Main
1942 *Crampton, Clair Beebe, 119 Main
1912 Fauver, Edgar, 327 High
1933 Fekety, Stephen Henry, 675 Main
1921 Felt, Paul Revere, Connecticut State Hospital
1900 Fisher, Jessie Weston, 28 Crescent
1927 Frank, Harry Selig, 144 Washington
1937 Geck, Otto Francis, Box 361
1931 †Gissler, Norman Edwin, 164 Court
1927 Grower, Julius Harry, 164 Court
1920 Harvey, Carl Clifford, 119 Main
1924 †Joyce, William Michael, 121 Main
1944 Katzenstein, Rolf Ewald, Middlesex Hospital
1928 LaBella, Louis Oronato, P. O. Box 417
1942 Lindsay, Marie Strom, Connecticut State Hospital
1925 Loffredo, Louis, 77 Crescent
1929 Magnano, Joseph, 100 Broad
1940 *McLeod, Christie Ellen, 28 Crescent
1934 Minor, Lloyd Wesley, 119 Main
1941 *Mozzer, Alexander John, Connecticut State Hospital
1896 Murphy, James, 101 Broad
1939 Palmieri, Mario Lorenzo, 43 South Main
1928 Piasta, Peter Ferdinand, 602 Main
1943 Rafkind, Abraham Benjamin, 108 Main
1934 *Roccapriore, Benjamin Anthony, 504 Main
1926 Russman, Charles, Connecticut State Hospital
1942 *Simon, Benjamin, Connecticut State Hospital
1929 Speight, Harold Edmund, 642 Main
1924 Sweet, Alfred Norton, 164 Court
1933 Tracy, Frederick Erwin, Old Mill Rd.
1919 Van Cor, Chester Arthur, Connecticut State Hospital
1942 Vinci, Vincent John, 258 William
1934 Waterman, Chester, 119 Main
1933 Whiting, Harry St. John, Connecticut State Hospital
1925 Wilder, Ella Annis, 80 South Main
1943 Wilk, Edward Kennard, Connecticut State Hospital
1922 Wrang, William Emil, 294 Main
1944 Yerbury, Edgar C., Connecticut State Hospital

OLD SAYBROOK

1941 Deming, Nelson Lloyd
1905 Granniss, Irwin, P. O. Box 312
1934 Greenberg, Aaron, Main

PORTLAND

1942 Alexander, Stanley Joseph, 229 Main
1944 Jacobson, Alan, Elmcrest Manor
1938 Prout, Edgar Bacon, 48 Bartlett
1941 *Ryan, V. Gerard, 25 Marlborough
1933 Schwartz, Philip Edward, 309 Main

SAYBROOK
Deep River

1939 Lobb, Russell Albert, 131 Main
1903 Pratt, Arthur Milton, P. O. Box 477
1932 *Tate, William James, Elm

OUT OF COUNTY

1924 Holley, Erving, Brattleboro Retreat, Brattleboro, Vermont
1904 Kingman, James Henry, 96 Everit, New Haven

## New Haven County Association

*President:* Ralph W. Nichols, 57 Trumbull St., New Haven
*Vice-President:* M. Heminway Merriman, 115 Prospect St., Waterbury
*Secretary:* Ralph E. McDonnell, 158 Whitney Ave., New Haven
*Councilor:* Herbert Thoms, 789 Howard Ave., New Haven

Annual Meeting, Fourth Thursday in April
Semi-Annual Meeting, Fourth Thursday in October

ANSONIA

1916 Aaronson, Michael S., 190 Main
1937 Alu, Anthony F., 290 Main
1935 *Blumenthal, Edward Jedediah, 88 Main
1938 Casagrande, John Joseph, 178 Main
1944 Davis, Melvin R., 5 Bank
1907 Parmelee, Edward Kibbe, 50 Main
1932 Renehan, John Michael, 100 Main
1924 Senfield, Maxon Major, 110 Main
1924 Thomas, John Joseph, 290 Main

BRANFORD

1934 Blanchard, Dana Lincoln, 87 Main
1931 *Bodie, William Joseph, 146 Montowese
1940 Carpinella, Michael Joseph, 48 Kirkham
1917 Gaylord, Charles Woodward, 93 South Main
1929 Levy, Nathan, 140 Montowese
1916 McQueen, Arthur Samuel, 187 Montowese

Pine Orchard

1919 Smith, George Milton

CHESHIRE

1911 Herr, Edward Albert, Main
1923 Moore, Wilbur John, Maple Ave.
1940 *Neff, William Everett, Jr., Main
1939 Oxnard, Edward Warren, Maple Ave.

DERBY

1927 Burns, George Dewey, 42 Seymour Ave.
1941 *D'Alessio, Charles Magno, 18 Elizabeth
1940 *D'Ambruoso, Dominic Charles, 3 Elizabeth
1944 *Davis, Donald Alan, 38 Elizabeth
1940 Dreher, Samuel Meyers, 282 Main
1944 *Narowski, John Joseph, 47 Seymour Ave.
1910 Parlato, Michael Antonio, 270 Elizabeth
1925 *Rentsch, Samuel Burton, 61 Seymour Ave.
1940 *Stygar, Joseph Stanislaus, 272 Main
1910 Treat, William Howard, 166 Minerva

EAST HAVEN

1940 *Balletto, Vincent, 535 Thompson Ave.
1940 Grenon, Ovilda Arzidas, 265 Main
1924 *Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

1941 *McGuire, Frank James, 29 Whitfield
1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
1943 Elkinton, Joseph Russell, 105 Clifford
1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
1944 Fischer, Alexander, 1324 Dixwell Ave.
1943 James, George R., 25 Central Ave.
1890 Joslin, George H., 2798 Whitney Ave.
1942 Lawrence, Edwin Alonzo, 175 Treadwell
1904 Lay, Walter Sidders, 2320 Whitney Ave.
1942 *McKeon, James Joseph, 1828 Dixwell Ave.
1938 Parente, Leonard, 126 Church
1927 *Slater, Morris, 1100 Dixwell Ave.
1942 *Wilcox, Frederick C., 157 Woodlawn

MADISON

1942 Hughson, Frances Gramling, Boston Post Rd.
1943 Rindge, Mila Elisabeth, Boston Post Rd.
1908 Rindge, Milo Pember, Boston Post Rd.

MERIDEN

1934 Affinito, Thomas, 128 West Main
1945 Brown, Marion R. Snyder, 3 Colony
1929 *Campbell, Sherbourne, 147 West Main
1928 *Caplan, Henry 27½ West Main
1939 Caplan, Max, 197 Cooke Ave.
1937 *Carey, William Clark, 61 Colony
1924 Carroll, William Edward, Undercliff
1937 Cohen, David Jerome, 3 Colony
1926 Conroy, Michael Joseph, 64½ East Main
1939 de La Vergne, Paul Mason, Undercliff
1927 DeRosa, Sylvester Frank, 29 Cook Ave.
1930 Foster, Edward Wendell, 147 West Main
1940 Fox, George Graham, 147 West Main
1921 Gibson, Cole Blease, Undercliff
1929 *Hall, William Edward, 147 West Main
1943 Harvey, Thomas Stoltz, 12 King
1941 *Katz, Irving, 42½ East Main
1944 Krochmal, Heinrich, 455 Broad
1939 *L'Heureux, Jerome Arthur, 455 Broad
1939 *Liebow, Averill Abraham, 12 King
1934 †Lirot, Stephen Leo Robert, 147 West Main
1907 Lockwood, Howard DeForest, 248 East Main
1934 *Mekrut, Joseph Anthony, 34½ West Main
1928 Mills, Bernard Litchfield, 94 East Main
1934 *Misuk, Joseph Francis, 489 Broad
1913 Murdock, Thomas Patrick, 147 West Main
1921 Otis, Fessenden Newport, 165 West Main
1920 Otis, Israel Sabine, 165 West Main
1932 Pennington, Harry Freeman, 455 Broad
1937 Petrucelli, Rocco Joseph, 147 West Main
1931 Pierson, Louis A., 199 West Main
1916 Quinlan, Raymond Vincent, 5 State
1913 Smith, David Parker, 199 West Main
1942 *Smith, Edward Rice, 199 West Main
1935 *Solomon, Charles Isadore, State School for Boys
1943 Solomon, Rebecca Zinsher, 294 Colony
1940 Stoddard, John Elias, 119 West Main
1934 *Strickland, Harold, 128 West Main
1931 Thompson, Lawrence Everett, Undercliff
1921 Tower, Arthur Augustus, 147 West Main
1936 *Van Antwerp, Lee Douglas, Undercliff
1940 Van Leuvan, James Sipple, 61 Colony
1945 *Wagner, Herbert Theodore, Jr., 24 Orange
1921 Wilson, James Alfred, 61 Colony

MILFORD

1938 *Barney, Walter Edward, 186 Broad
1932 Budau, John Harry Diederichs, 741 East Broadway
1942 Davis, George Breed, Milford Health Department
1913 Fischer, William John Henry, 3 Lafayette
1943 *Fischer, William J. H., Jr.

1929 Geib, Henry Albert, Zion Hill Rd.
1928 Hyde, Clinton John, 157 Gulf
1944 Langner, Helen P., 1 Shipyard Lane
1939 Lee, Frank Nelson, 56 Broad
1941 †Stetson, Charles Greaves, 114 Broad
1933 Stetson, Harry Warren, 114 Broad
1940 Viola, Carl Philip, 26 Cherry

### Devon

1934 *Andrus, Oliver Burton, 531 Daytona Ave.
1941 Lee, John Ranks, 21 Colonial

## NAUGATUCK

1941 Bluestone, David Harrison, 18 Hillside Ave.
1922 Duffy, Vincent Paul, 83 Meadow
1923 Hill, William Edward, 150 Meadow
1940 Kennedy, Charles Stephen, 175 Meadow
1938 *Reilly, Walter John, 170 Meadow
1937 Towne, Nehemiah Alvarado, 297 Church
1944 Weile, Fred William, 270 Church
1926 *Williams, Edward Everett, 269 Church
1942 Zonn, Seymour Israel, 365 North Main

### Union City

1935 Curran, Edwin Russell, 364 North Main
1940 *Tylec, Leo Louis, 359 North Main

## NEW HAVEN

1935 *Abbey, Edward Augustin, 255 Bradley
1937 *Abrashkin, Mortimer Dick, 1187 Chapel
1941 *Aiello, Louis James, 37 Maple
1921 Alderman, Irving Saunders, 204 Park
1925 Allen, Edward Pratt, 27 Elm
1902 Allen, Millard Filmore, 65 Dixwell Ave.
1893 Alling, Arthur Nathaniel, 257 Church
1932 Amatruda, Frank Gabriel, 542 Chapel
1908 Arnold, Harold Sears, 442 Temple
1930 *Arnold, Hermann Bruno, 49 Dwight
1940 *Barald, Fred Charles, 487 Dixwell Ave.
1920 Barker, Creighton, 258 Church
1908 Barrett, William Joseph, 265 Church
1896 Bartlett, Charles Joseph, 183 Bishop
1936 *Bassin, Alexander Lewis, 789 Howard Ave.
1930 Batelli, Clement Francis, 161 Church
1925 Battista, Anthony William, 111 Osborn Ave.
1934 *Bayne-Jones, Stanhope, 310 Cedar
1909 Beck, Frederick George, 193 York
1926 Behan, Edmund Joseph, 1370 Chapel
1931 Benedict, Mary Kendrick, 291 Whitney Ave.
1940 *Berlowe, Max Llewellyn, 315 Whitney Ave.
1920 Berman, Harry Loring, 1142 Chapel
1944 *Berneike, Robert R., 789 Howard Ave.
1940 *Biondi, Benedict, 120 Blatchley Ave.
1939 *Bishop, Courtney Craig, 158 Whitney Ave.
1907 Blake, Eugene Maurice, 303 Whitney Ave.
1922 Blake, Francis Gilman, 789 Howard Ave.
1927 Blodinger, Israel Edward, 291 Whitney Ave.
1911 Boardman, Albertus Kellogg, 441 Forbes Ave.
1922 Boardman, Emma Irene, 161 Church
1926 Bodie, John Allen, 221 Columbus Ave.
1939 Boisvert, Paul Leo, Chestnut Ridge Rd., Orange
1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.
1935 Brody, Bernard Stephen, 303 Whitney Ave.
1945 Brody, John, 291 Whitney Ave.
1940 *Brown, Warren Thompson, 333 Cedar
1938 †Bruckner, William J., 129 Whitney Ave.
1930 *Bumstead, John Henry, 256 Bradley
1942 Bunting, Henry, 310 Cedar
1943 Calabresi, Massimo, 614 Orange
1934 *Canfield, Norton, 789 Howard Ave.
1928 Capecelatro, Alfonso, 142 Columbus Ave.
1916 Carelli, Genesis Frank, 27 Elm
1943 *Carlson, Robert Irving, 710 Woodward Ave.
1932 *Celentano, Luca Eugene Humbert, 115 Howe
1943 *Centrone, Patrick Anthony, 253 West Carlisle
1892 Cheney, Benjamin Austin, 265 Church
1934 *Claiborn, Louie Nixon, 303 Whitney Ave.
1937 Clark Mildred Helen, 244 Sherman Ave.
1938 *Clarke, Clement Cobb, 158 Whitney Ave.
1935 *Climo, Samuel, 1172 Chapel
1923 Cobey, James Francis, 1210 Chapel
1922 Coffey, James Ryle, 216 Grand Ave.
1925 Cofrances, Louis William, 190 Winthrop Ave.
1904 Cohane, Timothy Francis, 400 Congress Ave.
1924 Cohen, William, 1195 Chapel
1917 Collins, William Francis, 66 Trumbull
1921 Colwell, Howard Spencer, 129 Whitney Ave.
1914 *Comfort, Charles Williams, Jr., 27 Elm
1931 Connolly, Arthur James, 59 Trumbull
1914 Conte, Harry Albert, 5 Elm
1939 *Conte, Mario Gero, 350 Grand Ave.
1943 *Conway, David Francis, Jr., 743 Winchester Ave.
1921 Cook, Robert Jay, 85 Whitney Ave.
1931 †Corradino, Charles Louis, 516 Howard Ave.
1944 Cramer, Sidney Leo, 789 Howard Ave.
1921 Creadick, Abraham Nowell, 79 Trumbull
1943 *Creadick, Robert Nowell, 77 Loomis Pl.
1936 Culotta, Charles Salvatore, 291 Whitney Ave.
1943 Curtis, William Boyd, 64 Trumbull
1940 *Cutler, Herman Shepard, 425 Forbes Ave.
1924 Dallas, Marion, 248 Bradley
1943 D'Amico, Joseph, 197 James
1935 *D'Amico, Michael, 303 Whitney Ave.
1934 Darrow, Daniel Cady, 789 Howard Ave.
1939 *Davis, Jachin Boaz, 158 Whitney Ave.
1920 Dayton, Arthur Bliss, 129 Whitney Ave.
1942 de Forest, Gideon Knapp, 256 Bradley
1920 Deming, Charles Kenneth, 257 Church
1922 Deming, Clyde Leroy, 789 Howard Ave.
1925 Dennehy, William James, 158 Whitney Ave.
1935 *D'Esopo, Joseph Nicholas, 789 Howard Ave.
1943 de Suto-Nagy, Ilona Krasso, 158 Whitney Ave.
1940 DiStasio, Frank, 251 Edwards
1943 Doff, Simon David, 1142 Chapel
1922 Duffy, William Core, 608 Whitney Ave.
1943 Durlacher, Stanley Henry, 310 Cedar
1943 *Epstein, Charles J., 265 Church
1923 Errico, Louis, 26 Elm
1945 Evans, Joseph Harold, 1488 Chapel
1925 Evans, Theodore Schlosser, 59 Trumbull
1943 Eveleth, Malcolm Standish, 789 Howard Ave.
1935 *Fenney, Philip William, 570 Elm St.
1941 *Feyder, Sidney, 789 Howard Ave.
1942 †Fiorito, Joseph Anthony, 303 Whitney Ave.
1929 Fiskio, Peter William, 307 Humphrey
1914 Flynn, Charles Thomas, 41 Trumbull
1929 *Flynn, Harold Aloysius, 464 Dixwell Ave.
1940 Foley, Francis Edward, 588 Ferry
1888 Foote, Charles Jenkins, 257 Church
1907 Ford, Alice Porter, 1400 Chapel
1929 Foster, Lewis Chandler, 256 Bradley
1925 *Fox, James Charles, Jr., 789 Howard Ave.
1943 Frazer, John Paul, 789 Howard Ave.
1924 Freedman, Barnett Philip, 322 George
1936 Freeman, David, 60 Trumbull
1940 *Friedman, Irving, 315 Whitney Ave.
1937 Fry, Clements Collard, 109 College
1941 *Fuldner, Russell Victor, 158 Whitney Ave.

1940 *Garofalo, Mario Louis, 258 Franklin
1938 Geiger, Arthur Joseph, 789 Howard Ave.
1939 *Gendel, Benjamin Robert, 113 Sherman Ave.
1937 *Gentile, Angelo Louis, 601 Chapel
1920 Geraci, Lucian Arthur, 730 Whitney Ave.
1937 *German, William John, 789 Howard Ave.
1923 Gettings, James Augustus, 209 Whalley Ave.
1924 Giamarino, Henry James, 291 Whitney Ave.
1943 Gillson, Reginald Eric, 255 Bradley
1926 Glazer, Morris, 1204 Chapel
1941 Godfried, Milton Simons, 789 Howard Ave.
1910 Goldberg, Samuel James, 43 Trumbull
1941 Goldberg, Samuel James, Jr., 43 Trumbull
1912 Goldman, George, 201 Park
1927 Goldstein, Morris, 451 George
1935 *Goldstein, Richard Moses, 333 Cedar
1941 *Granoff, Morris Aaron, 419 Whalley Ave.
1924 Greenhouse, Barnett, 107 Whitney Ave.
1927 Groark, Joseph Anthony, 145 Grand Ave.
1931 Grodin, Herman Wolmer, 840 Howard Ave.
1939 *Guida, Francis Paul, 107 Whitney Ave.
1936 Hankin, Morris Albert, 43 Trumbull
1930 *Harris, Benedict Richard, 315 Whitney Ave.
1937 Harris, Jesse Samuel, 176 Dwight
1931 Harrison, Elizabeth Ross, 255 Bradley
1935 Hart, James Clement, 820 Elm
1920 Harvey, Samuel Clark, 789 Howard Ave.
1937 *Hathaway, John Seabury, 109 College
1943 *Havill, Rupert A., 789 Howard Ave.
1941 Heinemann, Martin, 107 Whitney Ave.
1916 Hendricks, Albert Ludwig, 26 Trumbull
1907 Henze, Carl William, 466 Orange
1937 *Hess, Orvan Walter, 79 Trumbull
1930 Higgins, Joseph John, 48 Dwight
1922 Hillman, Maurice Manuel, 31 Howe
1916 Hirata, Isao, 1455 Chapel
1943 Hitchins, Clayton Stanley, 59 Trumbull
1943 Hodgkins, Charles Henry, 59 College
1943 *Hoff, Ebbe Curtis, 408 Whitney Ave.
1924 Howard, Albert Joseph, 432 Whitney Ave.
1935 Howard, Marion Edith, 789 Howard Ave.
1915 Hynes, Frederick Henry, 195 Church
1914 Jack, Gabriel Joseph, 412 Orange
1924 Jack, John Louis, 412 Orange
1936 Jackson, Edith Banfield, 333 Cedar
1943 *Jaffe, Samuel A., 146 Sherman Ave.
1927 Jenkins, Ralph Hathaway, 789 Howard Ave.
1933 Johnson, Carl Edward, 158 Whitney Ave.
1938 *Jordan, Robert Hough, 59 Trumbull
1937 Kahn, Eugen, 333 Cedar
1944 Kartin, Bernard Leon, 333 Cedar
1944 Katz, Harvey Warren, 291 Whitney Ave.
1942 *Kirby, Sam Bartholomew, 620 Dixwell Ave.
1938 *Klatskin, Gerald, 61 Edgewood Ave.
1928 *Klebanoff, Harry Erwin, 1497 Chapel
1917 Kleiner, Simon Bretzfelder, 315 Whitney Ave.
1944 Knobloch, Hilda Ruth, 14 Davenport Ave.
1940 *Koufman, William Bernard, 45 Trumbull
1942 *Krosnick, Gerald, 234 Ellsworth Ave.
1935 *Krosnick, Morris Yale, 291 Whitney Ave.
1937 Kushlan, Samuel Daniel, 303 Whitney Ave.
1940 Latimer, Marvin Luther, 129 Whitney Ave.
1942 *Laube, Paul Julius, 789 Howard Ave.
1936 *Lavietes, Paul Harold, 789 Howard Ave.
1915 Lear, Maxwell, 1172 Chapel
1935 Leddy, Percy Allen, 109 College
1939 Lehman, Edward Burton, 1142 Chapel
1941 *Lehndorff, Peter, 73 Howe
1944 Lennox, Margaret Agnes, 333 Cedar
1943 Leonard, Marion, 158 Whitney Ave.
1945 Lepreau, Frank James, Jr., 789 Howard Ave.
1923 Levin, Hyman Alexander, 1142 Chapel
1920 Levy, Daniel Frederick, 1288 Chapel
1905 Lewis, Dwight Milton, 169 Church
1923 Lewis, Robert Morton, 52 Trumbull
1911 Linde, Joseph Irving, City Hall
1943 *Lindskog, Gustaf Elmer, 789 Howard Ave.
1919 Little, Herman Clark, 303 Whitney Ave.
1944 Lockwood, John Salem, 789 Howard Ave.
1927 †Logan, William Joseph, 412 Whalley Ave.
1944 Lolli, Giorgio, 4 Hillhouse Ave.
1942 Lopatin, Colman, 119 Carmel
1942 Lowman, Robert Morris, 108 Livingston
1943 *Lutz, Walter G., 333 Cedar
1926 MacCready, Paul Beattie, 442 Temple
1927 Marshall, Carter Lee, 198 Dixwell Ave.
1928 Marvin, Harold Myers, 303 Whitney Ave.
1921 Massa, Anthony Francis, 24 Beers
1931 Mastroianni, Luigi, 248 Bradley
1925 Maurer, Lloyd Leslie, 41 Trumbull
1920 *Maynard, Harry Hilts, 882 Howard Ave.
1934 McAlenney, Paul Francis, Jr., 79 Trumbull
1944 *McCabe, Edward James, 109 College
1922 †McDonnell, Ralph Edward ,158 Whitney Ave.
1913 McGuire, William Charles, 104 Park
1899 McIntosh, Edward Francis, 307 Alden Ave.
1945 McNamara, William Joseph 45 Wall
1940 Mendelsohn, William, 442 Temple
1916 Mendillo, Anthony Joseph, 45 Trumbull
1933 Mendillo, John Carleton Francis, 255 Bradley
1941 *Merriman, Henry, 789 Howard Ave.
1938 *Mignone, Joseph, 291 Whitney Ave.
1942 Mogil, Marvin, 59 College
1930 Mongillo, Frank, 5 Elm
1942 *Moore, Donald Bernard, 588 Howard Ave.
1945 Morgan, Kenneth Remsen, 789 Howard Ave.
1916 Morse, Arthur Henry, 789 Howard Ave.
1943 *Mott, Frederick Edward, 75 Westwood Rd.
1922 Musselman, Luther Kyner, 107 Whitney Ave.
1944 Mylon, Ernst, 358 Central Ave.
1921 Nahum, Louis Herman, 1142 Chapel
1940 Nesbit, Robert Raymond, 1442 Chapel
1941 *Nesbitt, Samuel, 168 Prospect
1922 Newman, Joseph Thomas, 150 Shelton Ave.
1914 Nichols, Ralph Wilbur, 57 Trumbull
1932 *Nodelman, Jacob, 5 Elm
1933 O'Brasky, Louis, 1172 Chapel
1920 O'Brien, William Henry Joseph, 265 Church
1922 *O'Connor, Denis Stanislaus, 158 Whitney Ave.
1931 *Oughterson, Ashley Webster, 789 Howard Ave.
1936 Palmieri, Michael Walter, 551 Howard Ave.
1929 Paul, John Rodman, 789 Howard Ave.
1943 Pelliccia, Orlando, Jr., 525 Whitney Ave.
1941 *Peltz, William Learned, 158 Whitney Ave.
1922 Perrins, Harlan Bassett, 59 Trumbull
1925 Peters, John Punnett, 789 Howard Ave.
1927 Petrelli, Joseph, 455 Orange
1923 Philipson, Samuel, 315 Whitney Ave.
1909 Phillips, Frank Lyman, 303 Whitney Ave.
1935 Piazza, George Joseph, 78 Orchard
1942 *Piccolo, Pasquale A., 286 Humphrey
1931 *Pinn, Abraham Samuel, 75 Sherman Ave.
1927 Poole, Allan King, 107 Whitney Ave.
1938 Poverman, David, 67 Trumbull
1927 Powell, Wilson, 1266 Forest Rd.
1925 Powers, Grover Francis, 789 Howard Ave.
1934 *Rademacher, Everett Stanley, 442 Temple
1903 Rand, Richard Foster, 246 Church

1943 *Redlich, Fritz Carl, 333 Cedar
1941 *Riccio, Joseph Salvatore, 845 Grand Ave.
1924 Riccitelli, Mariano Louis, 476 Howard Ave.
1938 Rilance, Arnold Boon, 442 Temple
1937 *Robbins, Clarence Loveridge, 158 Whitney Ave.
1929 *Roberts, Frederick William, 129 Whitney Ave.
1920 Rogers, Orville Forrest, 109 College
1929 Rogowski, Bernhard Albert, 75 Whitney Ave.
1941 *Roth, Oscar, 61 Ellsworth Ave.
1944 Roth, Stefanie Zeimer, 61 Ellsworth Ave.
1932 Rothschild, Morris Loeb, 315 Whitney Ave.
1941 *Rozen, Alan Abraham, 224 Norton
1937 *Rubin, George Alan, 1155 Chapel
1914 Russell, Thomas Hubbard, 57 Trumbull
1922 Russell, Walter Irving, 317 Whalley Ave.
1920 Russo, Joseph Daniel, 255 Edwards
1921 Ryder, William Harold, 195 Church
1940 *Sadusk, Joseph Francis, Jr., 789 Howard Ave.
1933 Salinger, Robert, 256 Bradley
1944 Salter, William Thomas, 333 Cedar
1910 Sanford, Charles Edwin, 265 Church
1939 Savarese, Melchior F. R., 41 Howe
1911 Scarbrough, Marvin McRae, 47 Trumbull
1931 Scholl, Robert Frederick, 215 Whitney Ave.
1924 Scott, Clifton Russell, 215 Whitney Ave.
1920 Seabury, Robert Brewster, 315 Whitney Ave.
1916 Segnalla, Ernest, 613 Chapel
1923 Serafin, Peter James, 809 State
1937 *Shaffer, Thomas Eugene, 107 Whitney Ave.
1928 Shay, Francis Leo, 354 Alden Ave.
1923 Shea, Michael Stephen, 500 Howard Ave.
1915 Sheahan, William Lawrence, 59 College
1929 *Shure, Abraham Lewis, 85 Whitney Ave.
1923 Silverberg, Samuel Joshua, 315 Whitney Ave.
1913 Skiff, Stuart Ernest, 1194 Chapel
1944 Smirnow, Max Ruskin, 1142 Chapel
1923 Smith, Charles Seaver, 59 College
1942 *Smith, Frederick Francis, 84 Dixwell Ave.
1914 Smith, Marvin, 356 Humphrey
1940 Smith, Norman Nathaniel, 291 Whitney Ave.
1927 *Snurkowski, Charles Vincent, 487 Orange
1927 †Sperandeo, Anthony, 441 Orange
1896 Sperry, Frederick Noyes, 107 Whitney Ave.
1942 *Spiegel, Charles Markle, 829 Elm
1939 *Spinner, Samuel, 45 Trumbull
1907 Standish, Frank Billings, 193 York
1936 *Stevens, Marvin Allen, 256 Bradley
1916 Stewart, Harry Eaton, 262 Bradley
1925 Stone, Emerson Law, 129 Whitney Ave.
1920 Strauss, Maurice Jacob, 41 Trumbull
1897 Sullivan, John Francis, 1346 Chapel
1923 Sullivan, Thomas Joseph, 495 Orange
1936 *Thompson, Lloyd James, 333 Cedar
1915 Thoms, Herbert, 789 Howard Ave.
1911 Tileston, Wilder, 442 Temple
1923 Tyler, Margaret, 158 Whitney Ave.
1942 Vegliante, Michael E., 174 Bradley
1896 Verdi, William Francis, 27 Elm
1943 *Verstandig, Charles Coleman, Induction Center
1924 Vestal, Paul William, 79 Trumbull
1941 Vollero, Andrew, 469 Howard Ave.
1926 Wakeman, Edward Taylor, 129 Whitney Ave.
1945 Waldemar-Kertész, Johanna, 323 Alden Ave.
1919 Weil, Arthur, 291 Whitney Ave.
1942 Weir, Margaret Lathrop Bronson, 200 Edgehill Rd.
1944 *Welt, Louis Gordon, 74 Park
1942 *Wentworth, John Hall, 240 Oliver
1907 Wheatley, Louis Frederick, 61 Trumbull
1916 Whiting, Leonard Clark, 121 Whitney Ave.
1906 Whittemore, Edward Reed, 33 Whitney Ave.
1936 *Wies, Frederick Albert, 255 Bradley
1941 Wilkinson, Arthur Gilburt, 59 Trumbull
1931 Willner, Otto, 61 Trumbull
1935 Wilson, Hugh Monroe, 789 Howard Ave.
1931 *Wilson, William Rives, 58 Trumbull
1939 Winkler, Alexander Woodward, 789 Howard Ave.
1899 Winne, William Nelson, 1020 Whalley Ave.
1921 Winternitz, Milton Charles, 310 Cedar
1922 Winters, Sidney, 1175 Chapel
1895 Wurtenberg, William Charles, 445 St. Ronan
1924 *Yavis, John Constantine, 115 Dwight
1920 Yudkin, Arthur Meyer, 257 Church
1933 *Zimmerman, Harry Martin, 310 Cedar

## NORTH HAVEN

1941 *Allen, John Clinton, Quinnipiac Ave.
1941 *Cashman, Justin Laurence, Broadway
1943 Gillis, Grace Elaine, St. John
1913 Lang, William Peter, The Cedars
1940 Parrella, Louis Arnold, Broadway
1923 Taylor, Sterling Price, Broadway and Post Rd.

## SEYMOUR

1938 *Chobian, Joseph Aloysius, 159 Main
1941 Harvey, Edward Regis, 119 Main
1934 Rogol, Oscar, 135 Main

## SOUTHBURY

1942 Deutsch, Joyce Victoria, Southbury Training School
1935 Yannet, Herman, Southbury Training School

## WALLINGFORD

1943 †Boyarsky, Harry Morton, 450 Center
1932 †Breck, Charles Arthur, 176 North Main
1930 Carrozella, John Christy, 50 South Main
1941 Dayton, Theodore Read, Gaylord Farm
1942 Ferguson, James Fulton, Jr., 176 North Main
1942 Gushee, Edward Stockbridge, 187 North Main
1905 Lyman, David Russell, Gaylord Farm
1911 McGaughey, James David, 261 Center
1916 Morriss, William Haviland, Gaylord Farm
1942 *Murphy, Thomas Basil, 324 North Elm
1940 *Pelz, Kurt, 5 North Main
1919 Sheehan, Mark Thomas, 245 Center
1931 Spignesi, John Theodore, 37 North Main
1933 *Wilson, George Campbell, Gaylord Farm

## WATERBURY

1924 Allen, Harry Everett, 30 Prospect
1929 Atkins, Samuel Maurice, 63 Central Ave.
1923 Audet, Charles Henry, 42 Church
1942 *Backhus, Louis Charles, 79 Greenleaf Ave.
1910 Barber, Walter Lewis, Jr., 87 North Main
1937 *Berman, Bernard Alfred, 161 North Main
1908 Bevans, Theodore Frank, 111 West Main
1931 *Bizzozero, Orpheus Joseph, 20 Grove
1942 Blau, Rudolf, 47 Cooke
1939 Bonner, Robert Alexander, 51 West Main
1943 *Bonner, Robert Alexander, Jr., 103 North Main
1910 Brennan, Patrick Joseph, 135 West Main
1928 Brown, Abe Solomon, 58 Central Ave.
1943 *Bowen, Joseph John, Jr., 81 Alma
1940 *Burke, Joseph Francis, 135 West Main
1941 Cole, Clarence Hummer, 111 West Main
1935 Collins, Joseph Osborn, Robbins
1942 Coppeto, Carmine James, 220 East Main
1932 Corbett, Herbert John, 14 Central Ave.
1942 *Coshak, Morris, 20 East Main

1928 Cottiero, Thomas, 21 Cooke
1928 Curran, Harold Joseph, 111 West Main
1940 Damiani, Rudolph Andrea, 5 Cooke
1942 DeCristoforo, Ralph, 291 North Main
1907 Deming, Dudley Brainard, 67 Willow
1912 Dillon, John Henry, 325 East Main
1941 *Dionne, Ulric Albany, 230 South Elm
1927 Dreher, Alfred Charles, 171 North Main
1941 *DuBois, Robert Lionel, 135 West Main
1902 Dwyer, Patrick James, 95 North Main
1927 Edlin, Charles, 24 Central Ave.
1922 Fabricant, Samuel Elmer, 9 Cooke
1937 Finkelstein, William, 103 North Main
1926 Finn, Alfred Joseph, 164 West Main
1926 Fitzpatrick, Edward Earl, 83 East Main
1927 Foster, John Hess, 77 North Main
1928 Freiheit, John Martin, 85 Grove
1937 Fruin, John William, 74 Oakland Ave.
1909 Gancher, Jacob, 275 North Main
1923 Godfrey, Edward John, 135 West Main
1914 Good, William Murray, 63 Center
1915 Green, Jacques Henry, 171 North Main
1942 *Harty, John E., 101 North Main
1933 Harvey, Joseph LeRoy, 222 Ledgeside Ave.
1930 *Herrmann, Albert Edward, 101 North Main
1931 Hetzel, Joseph Linn, 103 North Main
1943 Hieronymus, Ethel Emilia, 101 North Main
1939 Hinchey, Richard James, 43 Central Ave.
1919 Jackson, Andrew Joseph, 20 East Main
1929 Jackson, Edward Joseph, 76 Center
1942 *Jennes, Milton Leo, 18 Crescent
1939 †Jennes, Sidney Weinberg, 135 West Main
1922 Johnson, Arthur August, 59 Central Ave.
1915 Johnston, Ernest Hillock, 18 Saving
1944 Karlin, Frank Lewis, 95 North Main
1914 Kirschbaum, Edward Harry, 20 Grove
1944 Koleshko, Lawrence Jacob, 72 Elizabeth
1940 *LaBrecque, Frederick Charles, 164 West Main
1922 Larkin, Charles Lewis, 101 North Main
1910 Lawlor, Michael Joseph, 158 North Main
1945 †Lenkowski, William John, 207 South Elm
1907 *Leonard, George Arthur, 79 North Main
1941 *Lewicki, Edward Stanley, 36 North Main
1924 Lombardi, Pasquale Frederick, 46 Prospect
1939 *Margolius, Norman Calvin, 125 Grove
1941 *Mayo, Elliott Russell, 185 Grove
1916 McGrath, John Henry, 309 East Main
1943 Meo, Richard Carl, 80 Central Ave.
1925 Merriman, Merritt Heminway, 115 Prospect
1897 Moriarity, James Ligouri, 52 Holmes Ave.
1928 Morrill, Harold Frost, 300 West Main
1932 Mullen, John Joseph, 135 West Main
1940 *Nelson, Roger Burdette, 24 Central Ave.
1929 Neuswanger, Chris Harold, 89 North Main
1942 *Pasetto, Edo, 1183 Hamilton Ave.
1923 Platt, Irving Smith, 30 Prospect
1943 Pollard, Robert Lonsdale, 24 Central Ave.
1901 Pomeroy, Nelson Asa, 96 Hillside Ave.
1940 *Post, Edward Andrew, 135 West Main
1943 Prior, John D., 64 Robbins
1931 Pyle, Edwin, 95 North Main
1916 Quinn, Raymond James, 730 Baldwin
1941 *Reichenbach, Alfred Edelbert, 165 North Main
1939 *Reynolds, Joseph Alban, 95 North Main
1944 *Rogawski, Alexander Simon, 103 North Main
1920 Root, James Harold, 103 North Main
1925 Ruby, Max Harold, 47 Prospect
1939 *Ruby, Robert James, 47 Prospect
1914 Ryder, Raymond Harrison, 52 Central Ave.
1941 *Saltzman, Jacob A., 135 West Main
1931 Sandulli, Gaetano Renato, 64 Cooke
1928 Santoro, Grace Marie, 95 North Main
1939 *Sayers, Daniel O'Connell, 278 East
1933 Shea, Vincent Timothy, 20 East Main
1941 *Sklaver, Joseph, 111 West Main
1935 Slavin, Joseph E., 79 North Main
1906 Smith, Egbert Livingston, 292 West Main
1915 Spicer, Edmund, 292 West Main
1931 *Staneslow, John Stanislovaitis, 95 North Main
1924 Stettbacher, Henry John, 28 Prospect
1906 Swenson, Andrew Clay, 43 Central Ave.
1916 Vastola, Anthony Patrick, 103 North Main
1920 Webber, Edwin Russell, 95 North Main
1944 Wertheimer, John, 195 North Main
1943 Zerkowitz, Frederick, 79 North Main

## WEST HAVEN

1929 †Appell, Harold Seymour, 354 Campbell Ave.
1938 †Chasnoff, John Arthur, 328 Main
1943 Cozzolino, Eugene Norris, 640 Savin Ave.
1923 Giannotti, Carl Charles, 399 Savin Ave.
1909 Gilmore, Joseph Leo, 191 Center
1943 Kessler, Frederick, 493 Campbell Ave.
1940 *Koster, Leo William, 354 Campbell Ave.
1904 Kowalewski, Victor Alexander, 597 Campbell Ave.
1930 Milano, Nicolas Antonio, 271 Elm
1923 *O'Connell, William Michael, 295 Main
1915 Rogers, Platt Harrison, 228 Elm
1933 Snavely, Marion Elizabeth, 546 Washington Ave.

## WOODBRIDGE

1940 *Perham, William Sidney, Newton Road

## OUT OF COUNTY

1941 †Bearg, Philip Arnold, P. O. Box 360, San Luis Obispo, California
1944 Blum, Isabelle, Fairfield State Hospital, Newtown
1907 Blumer, George, 65 North Madison Ave., Pasadena, California
1937 Case-Downer, Muriel, 157 Warrenton Ave., Hartford
1921 Dunham, Ethel Collins, 1815 45th, N. W., Washington, D. C.
1916 *Egan, John Joseph, U. S. Vets. Admin., Newington
1937 Eliot, Martha May, 1815 45th, N.W., Washington, D.C.
1942 Farley, Edward Brendon, Middlebury
1923 Garcia, Alphonso Gilbert, Moosup
1941 Gerstl, Bruno, Cedarcrest Sanatorium, Hartford
1940 †Goodrich, William Albert, Presbyterian Hospital, New York City
1896 Graves, Frederick George, Bethlehem
1941 Grillo, Vincent James, N. Y. Orthopedic Hospital, New York City
1943 Grossman, John Henry, 1708 Huntington Turnpike, Bridgeport
1942 *Hersey, Thomas F., MC-AUS
1929 Hughson, Donald Thomas, Bellevue Hospital, New York City
1927 Johnson, Harold Albert, R. F. D. #2, Watertown
1936 Klumpp, Theodore George, 170 Varick St., New York City
1943 Lencz, Edwin, 53 Howe Ave., Shelton
1927 *Lindsay, Merrill Kirk, 4553 South Chelsea Lane, Bethesda, Md.
1906 McLarney, Thomas Joseph, 67 Catherine St., Hartford
1917 Merrill, William Truman, 67 Fullers Lane, Milton, Mass.
1942 *Millen, Samuel R., Veterans Home, Rocky Hill

1941 Miller, Herbert Chauncey, Jr., Univ. of Kansas, Kansas City, Mo.
1938 Mucci, Lawrence Adolf, 141 South Mountain Dr., New Britain
1894 Peck, Robert Ellsworth, R. F. D. #2, Concord, New Hampshire
1942 Richter, Helen Grace, P. O. Box 43, Narbeth, Pa.
1944 Ryan, Allan James, Long Island College Hospital, Brooklyn, New York
1942 *Sinclair, Sydney Edgar, La Porte, Penna.
1891 Skinner, Clarence Edward, 170 Post Rd., Darien
1931 *Sullivan, Albert Joseph, 3413 Texas Ave., S. E., Washington, D. C.
1941 Sword, Brian Collins, 630 North Broadway, Yonkers, N. Y.
1942 Tarbell, Luther Allen, Oklahoma A. & M. College, Stillwater, Oklahoma
1945 *Taylor, Hoyt Chase, 85 Sachem St., Norwich
1900 Teele, Julia Ernestine, Box 31, Hall-Brooke Sanitarium, Greens Farms, Conn.
1940 *Thorne, Lewis, Lawson General Hospital, Atlanta, Ga.
1945 Tulin, Maurice, 440 West 34th, New York City
1941 *Vermooten, Vincent, c/oH. R. Robbins, 505 Hansberry, Germantown, Penna.
1902 Welch, Harry Little, P. O. 1071, Sea Cliff, L. I., N. Y.
1941 Wilson, Dwight E., Worthington Ridge, Berlin
1942 *Woodruff, Lorande Mitchell, 721 Huntington Ave., Boston, Mass.
1942 *Zaff, Fred, 143 Summit St., Chelsea, Mass.

## New London County Association

*President:* John F. O'Brien, The Seaside, Waterford
*Vice-President:* Harold W. Higgins, 40 Shetucket St., Norwich
*Secretary-Treasurer:* Thomas Soltz, 52 Huntington St., New London
*Councilor:* George H. Gildersleeve, 310 Main St., Norwich

Annual Meeting, First Thursday in April
Semi-Annual Meeting, First Thursday in October

### COLCHESTER

1935 Friedman, Irving, 16 Norwich Ave.
1921 Pendleton, Cyrus Edmund, 13 Main
1942 Schwarz, Hans Peter, 7 Broadway

### EAST LYME

Niantic

1941 Dart, Frederick Bond, 61 Main
1934 MacLeod, Edith Alice, State Farm for Women

### GRISWOLD

Jewett City

1937 *Ansell, Harvey Berle, 30 North Main
1916 McLaughlin, John Henry, 37 Main
1934 O'Neil, Martin Leo, 8 Park Sq.

### GROTON

1916 Barnum, Charles Gardner, 230 Thames
1918 Douglass, Edmund Latham, 188 Thames
1943 Goldmeier, Erich, 274 Thames
1934 Hewes, Carlisle Tyson, 242 Thames
1941 Kaschub, Robert W., Electric Boat Co.
1944 Sutton, Paul, 25 Poquonnock Rd.
1942 *Szlemko, Emil Alex, 25 Poquonnock Rd.

### LYME

1927 Ely, Julian Griffin, R. F. D. #2

### MONTVILLE

Uncasville

1944 Donohue, John Daniel
1936 *Lubchansky, Jacob Harris
1929 Rasmussen, Hans Norman

### NEW LONDON

1933 *Baron, Shirley Harold, 309 State
1933 *Becker, Joseph, 325 State
1928 Blank, Eric Henry, 240 Williams
1942 Brahms, Sigmund Arnold, 563 Ocean Ave.
1933 Brosnan, John Francis, 302 State
1916 Cheney, George Philip, 179 Montauk Ave.
1936 *Comstock, Edward Richard, 106 State
1938 DeAngelis, Louis, 252 Montauk Ave.
1909 Dunn, Frank Martin, 26 Broad
1931 Dyer, Charles Edward, 102 Montauk Ave.
1936 Ferguson, Helen Knox, 508 Montauk Ave.
1906 Ganey, Joseph Matthew, 205 Williams
1934 Gipstein, Edward, 181 Broad
1939 *Hartman, Frederick Bittinger, 58 Huntington
1922 Hendel, Isidor, 50 State
1902 Henkle, Emmanuel Alex, 51 Federal
1934 *Henkle, Robert Theodore, 51 Federal
1895 Heyer, Harold Hankinson, 70 Coit
1936 *Irwin, Harold Hyman, 325 State
1921 Kaufman, Charles, 308 State
1940 *Krinsky, Charles Morris, 325 State
1924 Labensky, Alfred, 85 Federal
1909 Lawson, Stuart Johnston, 116 Federal
1921 Lena, Hugh Francis, 154 Broad
1931 Loiacono, Anthony Joseph, 325 State
1939 *Moran, James Patrick, 52 Huntington
1941 *Morris, Joyce Stringer, Mohican Hotel
1934 Morse, Willard Jackson, 32 Channing
1921 Murray, Thomas J., 34 Huntington
1936 †Rapp, Albert Grant, 325 State
1940 *Sabloff, Jack, 325 State
1929 Satti, Charles John, 131 Montauk Ave.
1941 †Savage, Philip Joseph,, 86 State
1933 *Scoville, Dorothea Haven, 40 Channing
1938 Smilgin, Victor Edward, 265 Williams
1921 Soltz, Thomas, 52 Huntington
1929 Starr, Richard Mallory, 45 Huntington
1942 Sturtevant, James Melvin, 58 Huntington
1904 Sullivan, Daniel, 833 Ocean Ave.
1940 Sulman, Morris, 203 Montauk Ave.
1899 Taylor, John Clifton, 159 State
1933 Taylor, Robert Nelson, 159 State
1936 Ward, Lawrence Shapiro, 325 State
1925 Warren, Hill Freeman, 100 State
1922 Wellington, Harold Wentworth, 309 State
1935 *Wies, Carl Hendricks, 58 Huntington
1913 Wilson, Frank Emery, 302 State
1938 *Woodward, Joseph Cutler, 41 Huntington

### NORWICH

1910 Agnew, Robert Robertson, 257 Main
1942 Bielecki, Casimer Eugene, 35 Main
1908 Brophy, Edward Joseph, 10 Shetucket
1945 Bryan, Kathryn May, 2 Franklin
1916 Callahan, John William, 308 Main
1915 Campbell, Hugh Baird, 275 Broadway
1943 *Daly, Joseph Lawrence, Jr., Norwich State Hospital
1925 Dixon, Henry Campbell, 16 Franklin
1897 Donohue, James Joseph, 43 Broadway
1916 Driscoll, William Thomas, 257 Main
1942 Drobnes, Sidney, Norwich State Hospital
1942 Ferrara, Michael, Uncas-on-Thames

1916 Freeman, Albert Clark, 54 Broadway
1942 *Friedman, Emerick, Norwich State Hospital
1898 Gildersleeve, Charles Child, 310 Main
1927 Gildersleeve, George Harold, 310 Main
1945 Guthrie, Riley Henry, Norwich State Hospital
1935 Hale, Virginia Anne, Norwich State Hospital
1935 Higgins, Harold William, 40 Shetucket
1898 Higgins, Harry Eugene, 40 Shetucket
1938 *Kettle, Ronald Harry, Norwich State Hospital
1935 *Lukoski, Walter Anthony Francis, 16 Franklin
1936 Mahoney, Joseph John, 99 Main
1922 Manwaring, Ier Jay, East Great Plains
1922 Markoff, Kopland Karl, 16 Franklin
1937 *Moore, Maurice R., Laurel Hill Rd., R. #16
1935 Neumann, Virgil Frank, Uncas-on-Thames
1935 O'Connell, Patrick Henry, 10 Shetucket
1942 Oppenheimer, Kurt, 247 Main
1942 Opper, Lincoln, Norwich State Hospital
1936 Osgood, Charles, 257 Main
1942 *Pepe, Anthony James, Norwich State Hospital
1934 Quintiliani, Albert, 43 Broadway
1932 Rabinovitch, Alec, 5 Washington
1930 *Raymer, John George, 40 Shetucket
1935 Sears, Lewis, 257 Main
1938 Segel, Solam, 257 Main
1944 Smith, Bryce A., Uncas-on-Thames
1929 Suplicki, John William, 255 Main
1921 Sussler, David, 65 Main
1943 Thale, Thomas, Norwich State Hospital
1925 Thompson, Clarence George, 257 Main
1943 *Tissenbaum, Morris Joseph, Norwich State Hospital
1942 Toy, Charles Mallory, Norwich State Hospital
1931 Urquhart, Robert Glen, Uncas-on-Thames
1935 Weidman, William Harold, Uncas-on-Thames
1932 Wener, William Victor, 241 Main

TAFTVILLE

1933 Archambault, Henry Allard, 2 North Second Ave.
1935 *Bergendahl, Harold Andrew, 1 South Second Ave.

OLD LYME

1909 Devitt, Ellis King

STONINGTON

1934 *Haliday, Earle George, 168 Water
1934 Veal, William Thomas, 99 Water
1912 Williams, Charles Mallory, 174 Water

MYSTIC

1907 Allyn, Louis Maxson, 22 Library
1941 Fowler, Roger Nathaniel, 5 Library
1928 Hill, Edward Roland
1915 Maine, Thurman Park, 64 Washington
1941 *Ryley, Roger Noyes, 35 Willow

WATERFORD

1913 O'Brien, John Francis, The Seaside
1942 †Tombari, Seraphino Paul, The Seaside

OUT OF COUNTY

1937 Barry, Joseph Charles, 156 Main, Manchester
1942 Cohen, Louis Harold, 315 Whitney Ave., New Haven
1943 Gliserman, Edward, Eccles, West Virginia
1932 Griswold, Matthew, 154 Armory, New Haven
1937 Lund, Frederic Albert, Hotel Wyoming, Orlando, Fla.
1924 Raynolds, Randolph, 258 Bradley, New Haven

## Tolland County Association

*President:* LEONARD W. LEVINE, Ellington
*Vice-President:* CHARLES T. LAMOURE, Windham Center
*Secretary-Treasurer:* FRANCIS H. BURKE, MC–AUS
*Acting Secretary:* JOHN E. FLAHERTY, 42 Elm St., Rockville
*Councilor:* CHARLES T. LAMOURE, Windham Center

Annual Meeting, Third Tuesday in April
Semi-Annual Meeting, Third Tuesday in October

COVENTRY

SOUTH COVENTRY

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

MANSFIELD

MANSFIELD DEPOT

1942 Dayton, Neil Avon, State Training School and Hospital
1940 *Leonard, Robert John, State Training School and Hospital

SOMERS

1921 Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1908 Hanley, John Patrick, 15 Church
1941 Luckner, Wendelin George
1935 Schiavetti, Alfred, 11 Church

VERNON

ROCKVILLE

1933 *Burke, Francis Henry, 27 Park
1908 Dickinson, Francis McLean, 38 Elm
1923 Ferguson, Roy Cameron, 57 Union
1918 Flaherty, John Edward, 42 Elm
1921 Metcalf, Elliott Harrison, 50 Elm
1897 O'Loughlin, Thomas Francis, 26 North Park
1931 *Schneider, William, 34 Union

WILLINGTON

WEST WILLINGTON

1928 Converse, Frank Benjamin

OUT OF COUNTY

1918 LaMoure, Charles TenEyck, Windham Center
1937 Beckwith, Donald Macfarlane, 578 Thompson Ave., East Haven

## Windham County Association

*President:* ANDREW O. LAAKSO, 27 Broad St., Danielson
*VicePresident:* NATHAN SPECTOR, 59 Church St., Willimantic
*Secretary-Treasurer:* BRAE RAFFERTY, 807 Main St., Willimantic
*Councilor:* ROBERT C. PAINE, Thompson

Annual Meeting, Third Thursday in April
Semi-Annual Meeting, Third Thursday in October

CANTERBURY

1936 Baldwin, Helen

HAMPTON

1914 Marsh, Arthur Drought

KILLINGLY

Danielson

1935 Chartier, Gerard Marcel, 148½ Main
1928 *Garcin, Cecil Redvers, 7 Broad
1940 Laakso, Andrew Olavi, 27 Broad
1909 Perreault, Joseph Napoleon, 43 Main
1919 Tanner, Warren Avery, 36 Academy
1920 Todd, Frank Paige, 178 Main

MOOSUP

1940 *Couture, Arthur Joseph, 19 South Main

PLAINFIELD

1903 Chase, Arthur Alverdo, Railroad Ave.
1933 Gulino, Angelo James

PUTNAM

1942 *Bates, David Hinrichs, 28 Front
1934 Chapnick, Morton Herman, 168 Main
1941 *Margolick, Moses, 80 Main
1921 Phillips, Karl Tristram, 66 Main
1930 Prosser, Florence Dean, 158 Main
1922 Russell, John Jarvis, Bridge and Main
1934 Shepard, William Mac, 66 Main

THOMPSON

1903 Paine, Robert Child

NORTH GROSVERNORDALE

1936 *Roy, Joseph Lambert

WINDHAM

Willimantic

1935 Arnold, Morton, 781 Main
1939 Basden, Edward Herbert, 199 Church
1939 Carter, George Howard, 29 North
1901 Girouard, Joseph Arthur, 19 Union
1928 Kinney, Kenneth Kyle, 29 North
1925 *Ottenheimer, Edward Joseph, 29 North
1932 Rafferty, Brae, 807 Main
1916 Riordan, Michael Davitt, 59 Church
1936 *Roch, George Emile, 33 Church
1937 Rothblatt, Reuben, 672 Main
1914 *Shea, Richard Edward, 850 Main
1914 Smith, Fred Morse, 736 Main
1929 Spector, Nathan, 59 Church
1935 *Vernon, Sidney, 828 Main

WOODSTOCK

East Woodstock

1913 Pike, Ernest Reginald

OUT OF COUNTY

1944 Curtis, Alton Kallock, Pratt & Whitney Corp., Kansas City, Mo.
1883 Foster, Warren Woden, 4000 Cathedral Ave., Washington, D. C.
1932 Gilman, Ralph Lawrence, Storrs
1896 Hills, Laura Heath, Box 847, Winter Haven, Fla.
1927 *LaPalme, Joseph Antonio, 718 School St., Webster, Mass.

ASSOCIATE MEMBERS

1941 Burr, Harold Saxon, 333 Cedar, New Haven
1941 Fulton, John Farquhar, 333 Cedar, New Haven
1941 Haggard, Howard W., 4 Hillhouse Ave., New Haven
1942 Hamilton, James A., 789 Howard Ave., New Haven
1941 Hiscock, Ira Vaughn, 215 Highland, New Haven
1941 Long, Cyril N. Hugh, 333 Cedar, New Haven
1941 Mickle, Friend Lee, P. O. Box 1139, Hartford
1943 Schneider, Edward Christian, Wesleyan University, Middletown
1941 Welling, William Corcoran, Station A, Drawer K, Hartford

# ALPHABETICAL ROLL OF MEMBERS

## With date and place of graduation

Aaronson, M. S., Univ. & Bellevue '13, Ansonia
Abbey, E. A., Georgetown '30, New Haven
Abrahams, M., Tufts '31, New Canaan
Abrashkin, M. D., Maryland '32, New Haven
Adam, F. S., Yale '25, North Canaan
Adams, M., Johns Hopkins '29, Greenwich
Adzima, J. M., Maryland '27, Bridgeport
Affinito, T., McGill '31, Meriden
Agnew, R. R., Yale '08, Norwich
Aiello, L. J., Boston '35, New Haven
Akerson, I. B., Iowa '25, Bridgeport
Alderman, I. S., P. & S., N. Y. '19, New Haven
Aldwin, F. J., Yale '32, Stamford
Alexander, S. J., Univ. & Bellevue, Portland
Allen, E. P., Yale '24, New Haven
Allen, G. F., McGill '37, Hartford
Allen H. E., Bowdoin '19, Waterbury
Allen, H. S., Yale '04, Woodbury
Allen, J. C., Hahnemann '39, North Haven
Allen, M. F., Med. Chi., Phila. '95, New Haven
Allen, M. M., Woman's Medical '35, Hartford
Allen, W. M., Johns Hopkins '20, Hartford
Alling, A. N., P. & S., N. Y. '91, New Haven
Allyn, L. M., Pennsylvania '03, Mystic
Alpert, M., Yale '28, Bridgeport
Alu, A. F., Yale '20, Ansonia
Amarant, L., Vienna '32, Bridgeport
Amatruda, F. G., Yale '23, New Haven
Ames, W. G., P. & S., N. Y. '38, Essex
Amos, I. L., McGill '26, Danbury
Amoss, H. L., Harvard '11, Greenwich
Anderson, C. W., Harvard '34, Greenwich
Andrews, E. M., Harvard '30, West Hartford
Andrus, O. B., Univ. & Bellevue '32, Devon
Angus, L. R., Toronto '28, Haddonfield, New Jersey (Hartford County)
Ansell, H. B., Tufts '32, Jewett City.
Antell, M. J., Vermont '29, Bridgeport
Antupit, L., Jefferson '23, Hartford
Appell, H. S., Tufts '27, West Haven
Appell, P. H., Univ. & Bellevue '23, Bristol
Apsel, A., L. I. Coll. Hosp. '18, Bridgeport
Apter, H., George Washington '34, Hartford
Apuzzo, A. A. Tufts '36, Middletown
Archambault, H. A., Tufts '27, Taftville
Arnold, H. B., Yale '26, New Haven

Arnold, H. S., Yale '03, New Haven
Arnold, M., Harvard '29, Willimantic
Arons, M. R., Maryland '30, Hartford
Ashcroft, A. D., P. & S., N. Y. '35, Stratford
Ashley, H. C., Virginia '26, Winsted
Atha, H. G., Tufts '34, Thomaston
Atkins, S. M., Tufts '22, Waterbury
Audet, C. H., Maryland '17, Waterbury
Ayres, P. B., Toronto '32, Cos Cob
Backer, M., Yale '24, Bridgeport
Backhus, L. C., Syracuse '33, Waterbury
Backus, H. S., L. I. Coll. Hosp. '03, Hartford
Bailey, H., Maryland '22, Hartford
Bailey, N. H., P. & S., Balt. '11, Hartford
Baker, P. G., Vermont '33, Winsted
Bakunin, M. I., Jefferson '32, Bridgeport
Baldwin, H., Wom. Med. N. Y. '92, Canterbury
Balletto, V., Tufts '33, East Haven
Bancroft, H. A., Albany '16, Hartford
Banks, D. T., Fordham '12, Bridgeport
Bannon, F. M., Vermont '28, Stamford
Barald, F. C., Boston '36, New Haven
Barber, W. L., Jr., Univ. & Bellevue '07, Waterbury
Barker, C., Dartmouth '13, New Haven
Barker, D. C., Maryland '40, Fairfield
Barker, N. J., Toronto '26, Hartford
Barnes, F. H., N. Y. Homeo. '96, Stamford
Barney, W. E., Yale '35, Milford
Barnum, C. G., Yale '11, Groton
Baron, S. H., Cornell '27, New London
Barrett, W. J., Maryland '04, New Haven
Barry, J. C., Boston '33, Manchester (New London County)
Barstow, R. I., Jefferson '33, Norfolk
Bartlett, C. J., Yale '95, New Haven
Barton, P. N., Harvard '39, Hartford
Basden, E. H., Tufts '33, Willimantic
Bassin, A. L., Rochester '30, New Haven
Batelli, C. F., Yale '28, New Haven
Bates, D. H., L. I. Coll. Hosp. '39, Putnam
Battista, A. W., Tufts '24, New Haven
Bausch, C. P., Tufts '29, Hartford
Bayne-Jones, S., Johns Hopkins '14, New Haven
Beach, C. C., P. & S., N. Y. '82, Hartford
Beach, C. T., Yale '05, Hartford
Bearg, P. A., Yale '37, San Luis Obispo, Calif. (New Haven County)
Beatman, I., Tufts '27, Hartford
Beatrice, A. A., Tufts '29, Bristol
Beauchemin, J. A., Montreal '25, Middletown
Beaudry, J. H., McGill '13, Bridgeport
Beck, E. C., Yale '26, South Norwalk
Beck, F. G., Yale '03, New Haven
Beck, S. H., Rochester '34, Bridgeport
Becker, J., Univ. & Bellevue '29, New London
Beckwith, D. M., Harvard '34, East Haven (Tolland County)
Beebe, J. T., Columbia '38, Hartford
Behan, E. J., McGill '22, New Haven
Beizer, E., L. I. Coll. Hosp. '30, New York City (Hartford County)
Bell, J. S., Illinois '28, Ridgefield
Bellew, R. F., Tufts '37, Bridgeport
Benedict, M. K., Johns Hopkins '19, New Haven
Benoit, R. J., Georgetown '26, New Britain
Benton, P. E., P. & S., N. Y. '34, Stratford
Bergendahl, H. A., Tufts '33, Taftville
Bergin, T. J., Yale '99, Cos Cob
Berlowe, M. L., L. I. Coll. Hosp. '34, New Haven
Berman, B. A., Tufts '34, Waterbury
Berman, H. L., Yale '15, New Haven
Berne, E. L., McGill '35, Westport
Berneike, R. R., Western Reserve '41, New Haven
Bernstein, A., Yale '08, Bridgeport
Bernstein, D. J., Vermont '33, New Britain
Bestor, E. L., N. Y. Homeo. '07, Hartford
Bevans, T. F., Minnesota '03, Waterbury
Bick, J. W., Jr., Tulane '37, Hartford
Bidgood, C. Y., Virginia '20, Hartford
Biehn, D. M. F., Queen's '37, Fairfield
Biehn, S. L., Toronto '26, Fairfield
Bielecki, C. E., Tufts '39, Norwich
Bienkowski, J. G., Harvard '35, Torrington
Bingham, C. T., P. & S., N. Y. '32, Hartford
Biondi, B., Tufts '38, New Haven
Biram, J. H., Cornell '10, Hartford
Bird, F. S., Vermont '33, Bristol
Birge, H. L., Pennsylvania '33, Hartford
Bishop, C. C., Yale '30, New Haven
Bissell, A. H., Cornell '16, Stamford
Bixby, H., Tufts '35, Middletown
Bizzozero, O. J., Vermont '27, Waterbury
Blake, E. M., Yale '06, New Haven
Blake, F. G., Harvard '13, New Haven
Blanchard, D. L., Yale '31, Branford
Blank, E. H., Vermont '25, New London
Blass, G., Vienna '24, Stamford
Blau, R., Friedrich Wilhelms '20, Waterbury
Blodinger, I. E., Yale '25, New Haven
Blogoslawski, W. J., Georgetown '27, New Britain
Bloom, D. I., Tufts '35, Thompsonville
Bluestone, D. H., Syracuse '12, Naugatuck
Blum, I., Geneva '35, Newtown (New Haven County)
Blumenthal, E. J., L. I. Coll. Hosp. '32, Ansonia
Blumer, G., Cooper '91, Pasadena, California (New Haven County)
Boardman, A. K., Pennsylvania '99, New Haven
Boardman, E. I., Cornell '20, New Haven
Bobrow, A., Berne '36, Hartford
Bodie, J. A., Tufts '24, New Haven
Bodie, W. J., Georgetown '29, Branford
Bodley, G. H., Yale '07, New Britain
Bogin, M., Yale '26, Bridgeport
Boisvert, P. L., Rochester '34, New Haven
Bonner, R. A., Maryland '12, Waterbury
Bonner, R. A., Jr., Maryland '38, Waterbury
Booe, J. G., Med. Coll. Va. '19, Bridgeport
Booth, J. D., P. & S., N. Y. '26, Danbury
Borkowski, B. J., Georgetown '28, Bristol
Botsford, C. P., Yale '94, Hartford
Bowen, J. J., Jr., U. Maryland '41, Waterbury
Bowman, S. H., Hahnemann, Chicago '13, Stamford
Boyarsky, H. M., Tufts '31, Wallingford
Boyd, H., Harvard '21, South Manchester
Brackett, A. S., Jefferson '95, Bristol
Brackin, J. T., Jr., Penn. '36, Hartford
Bradeen, F. B., Pennsylvania '99, Essex
Bradley, E. T., Cornell '36, New Canaan
Bradley, T. R., Maryland '14, South Norwalk
Brahms, S. A., N. Y. U. '35, New London
Brainard, C. B., Yale '98, West Hartford
Brandon, K. F., Toronto '32, Hartford
Branon, A. W., Jefferson '13, Hartford
Brayton, H. W., Harvard '11, Hartford
Breck, C. A., Yale '30, Wallingford
Brecker, F. W., Tufts '28, East Hartford
Brennan, E. L., Ireland '23, Hartford
Brennan, P. J., Yale '07, Waterbury
Bretzfelder, K. B., Jefferson '16, New Haven

Brewer, F., P. & S., N. Y. '20, East Hartford (Fairfield County)
Brewer, T. F., Yale '26, Hartford
Bria, W. F., Rome '34, Cos Cob
Bridge, J. L., Harvard '03, Hazardville
Brier, H. D., N. Y. U. '34, Bridgeport
Bristoll, D. A., Pennsylvania '27, New Britain
Brochu, E. D., Boston '33, Danbury
Brodsky, M. E., Northwestern '26, Bridgeport
Brody, B. S., Yale '28, New Haven
Brody, J., Tufts '39, New Haven
Bronson, W. T., N. Y. U. '98, Danbury
Brooks, P. L., McGill '32, Bridgeport
Brophy, E. J., Yale '04, Norwich
Brosnan, J. F., Tufts '30, New London
Brown, A. S., Yale '26, Waterbury
Brown, M. R. S., Temple '43, Meriden
Brown, P. H., Vermont '26, Stamford
Brown, W. T., Texas '33, New Haven
Browne, F. A., Johns Hopkins '20, Hartford
Bruckner, W. J., Cornell '33, New Haven
Brunet, W. M., Virginia '11, Bridgeport
Bruskin, C. E., Leipzig '32, Hartford
Bryan, K. M., Hering '04, Norwich
Buccheri, F. S., Tufts '35, New Britain
Bucciarelli, J. A., Temple '31, New Canaan
Buck, B. J., Harvard '26, Hartford
Buckhout, G. A., Tufts '35, Bridgeport
Buckley, R. C., Yale '24, Hartford
Buckley, J. W., Georgetown '33, Bridgeport
Buckley, W. E., Boston '33, Middletown
Buckmiller, F. C., Vermont '14, Bridgeport
Buda, G. E., Zurich '37, Stratford
Budau, J. H. D., Yale '00, Milford
Bull, J. N., P. & S., N. Y. '78, Plainville
Bumstead, J. H., Johns Hopkins '23, New Haven
Bunnell, W. W., Yale '29, Farmington
Bunting, H., Harvard '36, New Haven
Buol, R. S., Harvard '23, New Britain
Burgdorf, A. L., Rush '31, Bloomfield
Burke, F. H., Georgetown '31, Rockville
Burke, J. F., Yale '31, Waterbury
Burlingame, C. C., Hahnemann, Chicago '08, Hartford
Burns, B. J., Georgetown '18, Bridgeport
Burns, F. M., Columbia P. & S. '39, Shelton
Burns, G. D., Yale '25, Derby
Burns, M. M., Texas '27, Hartford
Butler, N. G., Tufts '24, Hartford
Byrne, D. W., P. & S., N. Y. '27, Hartford

Cabaniss, J. T., P. & S., N. Y. '15, Hartford
Cacace, V. A., Loyola '39, Bridgeport
Calabresi, M., U. Florence '26, New Haven
Caldwell, D. M., McGill '19, South Manchester
Calhoun, H. A., Tufts '34, Middletown
Callahan, J. W., P. & S., Balt. '11, Norwich
Callender, E. F., Yale '12, Chester
Calverley, E. T. T., Woman Med. Pa. '08, Cairo, Egypt (Hartford County)
Calvin, C. V., Harvard '16, Bridgeport
Cammann, O. DeN., P. & S., N. Y. '33, New Canaan
Campbell, H. B., Pennsylvania '09, Norwich
Campbell, S., Vermont '23, Meriden
Canby, J. E., Jefferson '27, West Hartford
Canfield, N., Michigan '29, New Haven
Capacelatro, A., Tufts '19, New Haven
Caplan, H., Yale '27, Meriden
Caplan, M., Louisville '33, Meriden
Capobianco, A. P., N. Y. Med. Coll. '40, Bridgeport
Cappiello, S., Tufts '19, Hartford
Carelli, G. F., Yale '11, New Haven
Carey, T. C., Yale '28, Hartford
Carey, W. C., P. & S., N. Y. '33, Meriden
Carlin, C. H., Michigan '96, Torrington
Carlson, R. I., Yale '39, New Haven
Carniglia, E. F., Harvard '29, Hartford
Carpenter, R. M., Loyola '16, Stamford
Carpinella, M. J., Rochester '32, Branford
Carroll, F. P., Johns Hopkins '14, Bridgeport
Carroll, J. E., Boston '25, Hartford
Carroll, P. R., Jr., Georgetown '29, Bridgeport
Carroll, W. E., Dartmouth '14, Meriden
Carrozzella, J. C., L. I. Coll. Hosp. '28, Wallingford
Carter, E. B., Johns Hopkins '11, Hartford
Carter, G., Johns Hopkins '28, Greenwich
Carter, G. H., P. & S., N. Y. '35, Willimantic
Carvey, E. V., Yale '35, Wethersfield
Carwin, J. L., Meharry '32, Stamford
Casagrande, J. J., St. Louis '32, Ansonia
Case, E. P., Michigan, '11, West Hartford
Case-Downer, M., Boston '29, Hartford (New Haven County)
Cashman, J. L., Hahnemann '37, North Haven
Cassone, R., Vermont '41, Stamford
Castaldo, L. F., Tufts '37, Bridgeport
Caulfield, E. J., Johns Hopkins '20, Hartford
Celentano, L. E. H., Hahnemann '30, New Haven
Cenci, V. P., Tufts '29, Hartford
Centrone, P. A., P. & S., N. Y. '37, New Haven
Chaffee, J. S., Pennsylvania '97, Sharon
Chalmers, H. E., Tufts '06, New Britain
Chapnick, M. H., Jefferson '32, Putnam
Chartier, G. M., Boston '33, Danielson
Chase, A. A., Harvard '01, Plainfield
Chase, C. C., Vermont '24, Middletown
Chasnoff, J. A., L. I. Coll. Hosp. '36, West Haven
Cheney, B. A., Yale '90, New Haven
Cheney, G. P., Md. Coll. Med. '13, New London
Cheney, M. L., Vermont '17, Bridgeport
Chernaik, S. J., Jefferson '16, New Britain
Chester, L. L., U. of Vermont '38, New Britain
Childs, A. E., N. Y. U. '96, Litchfield
Chipman, S. S., McGill '28, Norwalk
Chobian, J. A., Loyola, '33, Seymour
Claiborn, L. N., Washington '27, New Haven
Clancy, J. J., Yale '35, Hartford
Claps, L. V., N. Y. U. '40, Greenwich
Clark, M. H., Women's Medical '33, New Haven
Clark, W. T., Queen's '34, Bridgeport
Clarke, C. C., Yale '32, New Haven
Clarke, R. DeB., Johns Hopkins '08, Hartford
Clason, F. P., Harvard '15, Hartford
Cleary, H. J., Tufts '29, Watertown
Clifford, M. L., Colorado '33, Hartford
Clifton, H. C., Pennsylvania '01, Bloomfield
Climan, M., P. & S., N. Y. '15, Hartford
Climo, S., Ohio '29, New Haven
Close, J. F., P. & S., N. Y. '25, Greenwich
Clow, H. L., Tufts '14, Newtown
Coates, S. P., Maryland '34, Suffield
Cobb, A. E., Yale '98, Canaan (Hartford County)
Cobey, J. F., Yale '16, New Haven
Cochran, L. B., Pennsylvania '93, West Hartford
Cody, G. R., Georgetown '36, South Norwalk
Cody, T. P., L. I. Coll. Hosp. '36, New Canaan
Coffey, J. R., Yale '07, New Haven
Cofrances, L. W., Jefferson '23, New Haven
Cogan, G. E., Georgetown '23, Hartford

Cogland, J. L., Vermont '34, Hartford
Cognetta, J. J., Vermont '36, Stamford
Cogswell, E. S., Harvard '12, Hartford
Cogswell, L. P., Harvard '33, Hartford
Cohane, T. F., Yale '97, New Haven
Cohen, D. J., Yale '32, Meriden
Cohen, L. H., Yale '31, New Haven (New London County)
Cohen, W., Yale '23, New Haven
Cohn, S. H., Boston '34, Hartford
Cole, C. H., Yale '32, Waterbury
Collins, J. O., Baylor '29, Waterbury
Collins, W. F., Yale '04, New Haven
Colmers, R. A., Vienna '37, Stamford
Colwell, H. S., Johns Hopkins, '14, New Haven
Comfort, C. W., Jr., Yale '11, New Haven
Compson, F. E. M., Boston '20, Middletown
Comstock, E. R., Tufts '33, New London
Conklin, C. S., Fordham '16, Bridgeport
Conlon, W. L., Jefferson '36, Manchester
Connolly, A. J., Georgetown '28, New Haven
Connolly, J. P., Georgetown, '36, Stamford
Connor, G. M., Boston '35, Plantsville
Connor, J. J., Yale '30, Hartford
Connors, E. R., Boston '31, Bridgeport
Conroy, M. J., Yale '20, Meriden
Conte, H. A., L. I. Coll. Hosp. '12, New Haven
Conte, M. G., Naples '35, New Haven
Converse, F. B., Eclectic, Cinn. '94, West Willington
Conway, D. F., Jr., P. & S., N. Y. '37, New Haven
Cook, G. F., Tufts '23, Plainville
Cook, R. J., Johns Hopkins '13, New Haven
Cooley, C. M., Yale '08, New Britain
Coppeto, C. J., Marquette '39, Waterbury
Corbett, H. J., Tufts '29, Waterbury
Corcoran, M. A., Tufts '30, Hartford
Corey, W. VanA., George Washington '33, Hamden
Cornelio, F. J., Georgetown '34, Winsted
Corradino, C. L., Tufts '29, New Haven
Corridon, J. D., Georgetown '28, South Norwalk
Coshak, M., Boston '37, Waterbury
Costanzo, J. J., Illinois '05, Stamford
Costanzo, R. E., Loyola '14, Stamford
Costello, H. N., Johns Hopkins '10, Hartford
Cotterio, T., Yale '26, Waterbury
Couch, F. H., Yale '30, Cromwell
Couch, M. W., Minnesota '27, Cromwell
Couture, A. J., Boston '32, Moosup
Cox, R. B., McGill '02, Collinsville
Coyle, A. E. M., Wom. Med. Pa. '12, Windsor Locks
Coyle, B. J., Georgetown '18, Windsor Locks
Cozzolino, E. N., Harvard '33, West Haven
Cragin, D. B., Harvard '02, Hartford
Craig, G. M., Harvard '20, Middletown
Craighill, M. D., Johns Hopkins '24, Philadelphia, Penn. (Fairfield County)
Cram, G. E., P. & S., N. Y. '01, Glenbrook
Cramer, S. L., N. Y. Medical '41, New Haven
Crampton, C. B., Yale '37, Middletown
Crane, J. E., Vermont '39, Stamford
Crane, R. W., Yale '05, Stamford
Crawley, G. A., Temple '28, West Hartford
Creadick, A. N., Pennsylvania '08, New Haven
Creadick, R. N., Yale '37, New Haven
Creaturo, N. E., Boston '31, Bridgeport
Crispin, M. A., Temple '41, Bridgeport
Crosby, E. H., Yale '28, Hartford
Cullen, J. R., Georgetown '36, Hartford
Culotta, C. S., Yale '28, New Haven
Cunningham, J. M., Texas '26, Hartford
Cunningham, R. D. M., Yale '30, Stamford
Curley, W. H., Cornell '08, Bridgeport
Curran, E. R., Jefferson '24, Union City
Curran, H. J., Tufts '24, Waterbury
Curran, P. J., P. & S., N. Y. '01, Bridgeport
Curtis, A. K., Tufts '05, Kansas City, Mo. (Windham County)
Curtis, B. H., P. & S., N. Y. '36, Hartford
Curtis, W. B., P. & S., N. Y. '34, New Haven
Cushman, L. A., Harvard '24, West Hartford
Cutler, H. S., St. Louis '37, New Haven

D'Alessio, C. M., Maryland '37, Derby
Daley, L. W., McGill '30, New Britain
Dallas, M., Boston '22, New Haven
Dalton, G. H., Yale '12, New Britain
Daly, C. W., P. & S., Balt. '10, Hartford
Daly, J. L., N. Y. U. '33, Norwich
Daly, W. P., Georgetown '17, Hartford
D'Ambruoso, D. C., P. & S., N. Y., '36, Derby
Damiani, R. A., Tufts '33, Waterbury
D'Amico, J., U. Rome '37, New Haven
D'Amico, M., Yale '31, New Haven
Danaher, T. J., Yale '28, Torrington
D'Andrea, F. H., Yale '29, Stamford
Darrow, D. C., Johns Hopkins '20, New Haven
Darrow, J. E., Tufts '28, New Britain
Dart, F. B., Maryland '23, Niantic
Davenport, A. K. P., South Carolina '03, Hartford
Davis, D. A., Hahnemann '36, Derby
Davis, G. B., Vermont '24, Milford
Davis, J. B., Kansas '33, New Haven
Davis, J. E., Johns Hopkins '19, Hartford
Davis, J. S., Boston U. '36, South Norwalk
Davis, M. R., Howard '24, Ansonia
Davis, T. F., Tufts '21, Fairfield
Davol, R. T., P. & S., N. Y. '41, Greenwich
Dawson, L. M., Queen's '09, Hartford
Day, F. L., Bellevue '93, Bridgeport
Dayton, A. B., John Hopkins '15, New Haven
Dayton, N. A., Ohio '15, Mansfield Depot
Dayton, T. R., Harvard '25, Wallingford
Dean, S. R., Michigan '34, Stamford
DeAngelis, L., Virginia '36, New London
DeBonis, D. A., Naples '90, Hartford
DeCristoforo, R., Tufts '37, Waterbury
DeForest, G. K., Yale '32, New Haven
DeKlyn, W. B., Temple '41, Danbury
de la Vergne, P. M., McGill '35, Meriden
Delohery, C. L., Temple '26, Danbury
DeLuca, H. R., George Washington '16, Bridgeport
DelVecchio, L. F., Georgetown '31, Bridgeport
Deming, C. D., Johns Hopkins '10, Hartford
Deming, C. K., P. & S., N. Y. '17, New Haven
Deming, C. L., Yale '15, New Haven
Deming, D. B., P. & S., N. Y. '01, Waterbury
Deming, E. A., Johns Hopkins '08, Hartford
Deming, N. L., P. & S., N. Y. '93, Old Saybrook
Denne, T. H., Vermont '05, West Hartford
Dennehy, W. J., Yale '18, New Haven
DePasquale, F. L., Pennsylvania '26, Hartford
DePasquale, J. A., Pennsylvania '36, Hartford
DeRosa, S. F., Jefferson '24, Meriden
Derwin, J. J., Georgetown '30, Winsted
Desmond, W. F., Yale '25, Newtown
D'Esopo, J. N., McGill '31, New Haven
de Suto-Nagy, I. K., Royal Hung. '15, New Haven
Deutsch, J. V., L. I. Coll. Hosp. '36, Southbury
DeVito, M. J., Vanderbilt '28, Hartford

Devitt, E. K., Maryland '07, Old Lyme
DeWitt, E. N., Pennsylvania '17, Bridgeport
Diamond, E. H., Breslau '32, Norwalk
Dichter, C. L., Md. Coll. Med. '05, Stamford
Dichter, I. S., Jefferson '31, Stamford
Dickinson, F. McL., P. & S., N. Y. '05, Rockville
Dignam, B. S., Yale '35, Thompsonville
Dignam, E. A., Med. Coll. Va. '28, Hartford
Dillon, J. H., Yale '04, Waterbury
Dinan, H. P., Tufts '38, Stratford
Dinsmore, W. W., Johns Hopkins '07, Hartford
Dion, A. J., Tufts '28, Hartford
Dion, J. A., Georgetown '37, Hartford
Dionne, U. A., Tufts '30, Waterbury
Diskan, A. E., Temple '37, Manchester
DiStasio, F., Maryland '33, New Haven
Dixon, H. C., Bowdoin '17, Norwich
Dobbs, W. G. H., Rochester '34, Torrington
Dodd, B., P. & S., N. Y., '33, Hartford
Doerr, W. J., Erlangen '40, Broad Brook
Doff, S. D., L. I. Col. '39, New Haven
Donnelly, S. P., Georgetown '24, New Britain
Donner, S., Cornell '33, Hartford
Donohue, B. F., Yale '03, Bristol
Donohue, J. D., Baltimore '09, Uncasville
Donohue, J. J., P. & S., Balt. '96, Norwich
Donovan, W. F., Boston '31, Hartford
Dorian, G. D., Hahnemann '39, New Britain
Dorian, N. E., Maryland '17, New Britain
Dorion, R. H., Vermont '32, Stamford
Douglass, E. L., L. I. Coll. Hosp. '16, Groton
Downs, E. F., Johns Hopkins '37, New York City (Litchfield County)
Dray, E. J., Jefferson '09, New Britain
Dreher, A. C., Yale '23, Waterbury
Dreher, S. M., Temple '37, Derby
Driscoll, J. J., Vermont '25, Danbury
Driscoll, W. T., P. & S., Balt. '12, Norwich
Drobnes, S., Freiburg '37, Norwich
DuBois, F. S., Rush '31, New Canaan
DuBois, R. L., Maryland '35, Waterbury
Dudac, T. W., Georgetown '33, Southington
Duffy, L. T., Tufts '34, Hartford
Duffy, V. P., Maryland '17, Naugatuck
Duffy, W. C., Johns Hopkins '14, New Haven
Duksa, W. J., Georgetown '37, Hartford
Dunham, E. C., Johns Hopkins '18, Washington, D. C. (New Haven County)
Dunn, F. M., Baltimore '08, New London
Dunn, G. W., Baltimore '09, New Britain
Dunne, E. P., Maryland '18, Unionville
Dunne, R. E., Harvard '19, Hartford
Durkee, R. E., Jr., Harvard '36, Hartford
Durlacher, S. H., Yale '38, New Haven
Duzmati, P. P., Jefferson '36, Bridgeport
Dwyer, P. J., N. Y. U. '97, Waterbury
Dwyer, W., Johns Hopkins '13, Hartford
Dyer, C. E., Tufts '28, New London

Earle, B. B., Rush '30, Glastonbury
Eckert, G. R., Tufts '33, Danbury
Eddy, M. H., Harvard '35, Bridgeport
Edgar, K. J., Oregon '31, Bridgeport
Edlin, C., Tufts '25, Waterbury
Edson, R. C., Jefferson '31, Hartford
Edson, R. H., Cornell '35, Shelton
Egan, J. J., Maryland '07, Newington (New Haven County)
Egee, J. B., Hahnemann '34, Newtown
Eimas, A., Tufts '30, Bridgeport
Eisenberg, S. E., Rochester '39, New Britain
Eliot, M. M., Johns Hopkins '18, Washington, D. C. (New Haven County)
Elkinton, J. R., Harvard '37, Hamden
Elliot, K. G., Tufts '26, Hartford
Elliott, J. R., Boston '32, Canaan
Ellis, F. D., Jr., Pennsylvania '18, New Britain
Ellis, L. G., Jefferson '20, Hartford
Ellison, F. S., Yale '34, Hartford
Ellrich, D. L., Jefferson '28, Westport
Elmer, E. O., P. & S., Balt. '94, Hartford
Ely, J. G., Harvard '23, Lyme
Ematrudo, F. R., Eclectic, Cinn. '21, Hamden
Emmett, F. A., Yale '02, Hartford
Enander, F. C., Tufts '22, New Britain
English, C. F., St. Louis '12, Winsted
Epstein, C. J., Yale '29, New Haven
Errico, L., Yale '21, New Haven
Esposito, J. J., P. & S., N. Y. '37, Bridgeport
Evans, J. H., Boston U. '02, New Haven
Evans, T. S., P. & S., N. Y. '21, New Haven
Evarts, J., P. & S., N. Y. '29, Cornwall Bridge
Eveleth, M. S., Johns Hopkins '38, New Haven
Ewell, J. W., Harvard '36, Farmington

Fabricant, S. E., Jefferson '19, Waterbury
Fagan, F. X., Cornell '33 Waterbury (Hartford County)
Fancher, H. W., Maryland '25, Thompsonville
Farland, V. L., Montreal '25, Hartford
Farley, E. B., Yale '11, Middlebury (New Haven County)
Farquhar, L. R., Yale '37, Avon
Fauver, E., P. & S., N. Y. '09, Middletown
Fawcett, G. G., Cornell '15, South Norwalk
Fay, W. J., Harvard '14, Hartford
Feeney, T. M., Boston '36, Hartford
Fekety, S. H., Tufts '30, Middletown
Felt, P. R., Dartmouth '10, Middletown
Felty, A. R., Johns Hopkins '20, Hartford
Fenney, P. W., Tufts '31, New Haven
Ferguson, H. K., Univ. & Bellevue '32, New London
Ferguson, J. F., Jr., Yale '40, Wallingford
Ferguson, R. C., Yale '20, Rockville
Ferrara, M., Marquette '35, Norwich
Feyder, S., Rochester '36, New Haven
Filson, R. M., Queen's '15, West Hartford
Fincke, C. L., Harvard '28, Stamford
Findorak, F. G., Georgetown '37, Bridgeport
Fine, B., Jefferson '32, Stamford
Fine, J., Pennsylvania '31, Stamford
Finesilver, E. M., Johns Hopkins '24, Hartford
Fink, L., Leipzig '23, Bridgeport
Finkelstein, W., Harvard '34, Waterbury
Finkelstone, B. B., P. & S., Balt. '10, Bridgeport
Finley, G. C., Tufts '24, Hartford
Finn, A. J., Bowdoin '21, Waterbury
Finn, E. J., Yale '10, Shelton
Fiorito, J. A., Washington '37, New Haven
Fischer, A., U. of Paris '36, Hamden
Fischer, W. J. H., Yale '11, Milford
Fischer, W. J. H., Jr., P. & S., N. Y. '41, Milford
Fisher, J. G., U. of Paris '11, Grenwich
Fisher, J. W., Wom. Med. Pa. '93, Middletown
Fiske, M., Boston '27, Stamford
Fiskio, P. W., Yale '27, New Haven
Fitzpatrick, E. E., Maryland '15, Waterbury
Fitzpatrick, W. F., Cornell '38, Norwalk
Flaherty C. V., Yale '10, Hartford
Flaherty, J. E., Georgetown '08, Rockville
Flanagan, E. D., St. Louis '35, South Norwalk

Flanagan, W. F., Fordham '17, New Britain
Fleck, H. W., Jefferson '96, Stratford
Fleish, M. C., Tufts '40, Hartford
Flynn, C. T., Yale '11, New Haven
Flynn, H. A., Yale '27, New Haven
Flynn, W. H., Maryland '16, Bristol
Foley, F. E., Yale '14, New Haven
Foley, F. X., Boston '34, Bridgeport
Foote, C. J., Harvard '87, New Haven
Ford, Alice P., Women's Coll. of Penn. '04, New Haven
Formichella, J. B., Naples '98, Bridgeport
Foster, E. W., Harvard '24, Meriden
Foster, J. H., Pennsylvania '17, Waterbury
Foster, L. C., Harvard '23, New Haven
Foster, W. W., Harvard '82, Washington, D. C. (Windham County)
Fowler, R. N., P. & S., N. Y. '34, Mystic
Fox, G. F., U. of Vermont '37, Hartford
Fox, G. G., Harvard '34, Meriden
Fox, J. C., Jr., Johns Hopkins '20, New Haven
Frank, H. S., P. & S., N. Y. '24, Middletown
Frazer, J. P., U. Rochester '39, New Haven
Freedman, B. P., Yale '20, New Haven
Freeman, A. C., Vermont '13, Norwich
Freeman, D., Yale '24, New Haven
Freeman, J. J., Temple '33, Newington
Freiheit, J. M., Yale '27, Waterbury
Friedberg, S., L. I. Coll. Hosp. '28, Stamford
Friedman, E., Buffalo '34, Norwich
Friedman, I., George Washington '31, Colchester
Friedman, I., Yale '33, New Haven
Friedman, N. H., Tufts '33, Stratford
Friedman, S., Boston '31, Newtown
Friend, A. E., Queen's '22, South Manchester
Friery, C. M., Boston '29, Hartford
Fritz, J., Vienna '15, Hartford
Frost, L. H., Vermont '13, Plainville
Frothingham, J. G., Harvard '35, New Canaan
Fruin, J. W., L. I. Coll. Hosp. '08, Waterbury
Fry, C. C., Northwestern '24, New Haven
Fuldner, R. V., P. & S., N. Y. '33, New Haven
Fuller, R. H., Tufts '38, Simsbury
Fulstow, M., Tufts '20, Fairfield
Furniss, H. W., Howard '91, Hartford

Gaberman, D., P. & S., N. Y. '20, Hartford
Gade, C. J., Yale '10, Bridgeport
Gaetz, T. H., McGill '24, Shelton
Gaffney, C. B., Loyola '30, Bridgeport
Gaffney, J. J., Loyola '30, Danbury
Galinsky, D., Tufts '36, Hartford
Gallivan, J. N., Tufts '35, East Hartford
Gallo, F., Jefferson '34, Winsted
Gancher, J., L. I. Coll. Hosp. '06, Waterbury
Gandy, R. A., Virginia '27, Stamford
Gandy, R. R., Pennsylvania '99, Stamford
Ganey, J. M., P. & S., N. Y., '04, New London
Garbelnick, D. A., Boston '17, Bridgeport
Garcia, A. G., Vermont '21, Moosup (New Haven County)
Garcin, C. R., McGill '25, Danielson
Gardner, C. W., Maryland '01, Bridgeport
Gardner, N. H., Tufts '34, East Hampton
Garland, R. B., P. & S., Balt. '13, Hartford
Garlick, G. B., Yale '12, Bridgeport
Garofalo, M. L., Naples '35, New Haven
Garston, L. E., St. Louis '30, Torrington
Gates, A. B., L. I. Coll. Hosp. '12, Greenwich
Gaylord, C. W., Yale '15, Branford
Geck, O. F., Lushing Maximilions '25, Middletown
Geer, W. A., Yale '34, Bridgeport
Geetter, I. S., Jefferson '29, New Britain
Geib, H. A., Univ. & Bellevue '14, Milford
Geiger, A. J., Harvard '30, New Haven
Gendel, B. R., Tulane '35, New Haven
Genovese, F. T., Univ. & Bellevue '29, Danbury
Genovese, S., Cornell '11, Danbury
Gentile, A. L., Boston '29, New Haven
Geraci, L. A., P. & S., N. Y., '17, New Haven
German, W. J., Harvard '26, New Haven
Gerow, G. H., U. of Toronto '24, Westport
Gerstl, B., Vienna '27, Hartford (New Haven County)
Gettings, J. A., Jefferson '16, New Haven
Giamarino, H. J., Maine '06, New Haven
Giannotti, C. C. Albany '18, West Haven
Gibson, C. B., Atlanta '14, Meriden
Gibson, D. F., Yale '27, Danbury
Gibson, F. D., Syracuse '35, Hartford
Gilday, J. L., Eclectic, Cinn. '13, Bridgeport
Gildea, M. A., Buffalo '24, Bridgeport
Gildersleeve, C. C., Yale '96, Norwich
Gildersleeve, G. H., Yale '23, Norwich
Giles, N. W., Vermont '21, Stamford
Gill, M. H., Yale '96, Hartford
Gillespie, H., Jefferson '34, Hartford
Gillette, A. T., Cornell '08, Woodbury
Gillis, G. E., Tufts '37, North Haven
Gills, W. L., Johns Hopkins '12, Hartford
Gillson, R. E., Vermont '29, New Haven
Gilman, R. L., Harvard '29, Storrs (Windham County)
Gilmore, J. L., Yale, '04, West Haven
Giobbe M. E., Tufts '29, Torrington
Giorgio, N. A., L. I. Coll. Hosp. '25, Hartford
Gipstein, E., Jefferson '31, New London
Girouard, J. A., Baltimore '99, Willimantic
Gissler, N. E., Yale '28, Middletown
Giuliano, L. A., Tufts '32, South Norwalk
Giuliano, S., Tufts '30, Hartford
Glass, G. C., Yale '31, Hartford
Glass, W. H., Duke '37, Hartford
Glaubman, H. M., Yale '27, Hartford
Glazer, M., Tulane '22, New Haven
Glazier, J. R., Harvard '22, West Hartford
Gliserman, E., Boston U. '38, West Virginia (New London County)
Goddard, H. B., Harvard '24, East Hartford
Godfrey, E. J., Georgetown '15, Waterbury
Godfried, M. S., Yale '36, New Haven
Goff, C. W., Illinois '24, Hartford
Gold, J. D., P. & S., N. Y. '91, Bridgeport
Gold, L. H., N. Y. Med. '32, Hartford
Goldberg, I. S., Creighton '33, Torrington
Goldberg, S. J., Yale '07, New Haven
Goldberg, S. J., Jr., Harvard '36, New Haven
Goldenberg, J. J., Dalhousie '26, Hartford
Goldman, G., Yale '10, New Haven
Goldmeier, E., Frankfurt '39, Groton
Goldschmidt, M., Virginia '38, New Britain
Goldstein, M., Yale '24, New Haven
Goldstein, R. M., Johns Hopkins '30, New Haven
Goldys, F. M., Tufts '26, Danbury
Golomb, E. F., Woman's Med. '38, Bridgeport
Golston, H., Med. Coll. of Virginia '26, Hartford
Good, W. M., Yale '09, Waterbury
Goodell, R. A., Harvard '28, Hartford
Goodrich, C. A., P. & S., N. Y. '96, Hartford
Goodrich, W. A., P. & S., N. Y. '35, New York City (New Haven County)
Gordon, W. F., L. I. Coll. Hosp. '96, Danbury

Gore, M. A., Maryland '18, Bristol
Gorham, G. V., Michigan '30, Norwalk
Gosselin, G. A., Vermont '15, Hartford
Gould, M. M., Tufts '31, Hartford
Gourlie, H. W., Harvard '31, Thompsonville
Grady, J. F., P. & S., N. Y. '32, Stamford
Granniss, I., Yale '96, Old Saybrook
Granoff, M. A., Chicago '37, New Haven
Grant, A. S., Univ. & Bellevue '08, New Britain
Grant, R. F., Albany '38, Cromwell
Grau, L. C., Dartmouth '12, Hartford
Graves, F. G., Yale '92, Bethlehem (New Haven County)
Gray, A. S., Bellevue '15, West Hartford
Gray, H. J., St. Louis U. '21, Hartford
Green, H. H., Johns Hopkins '31, South Norwalk
Green, J. H., Univ. & Bellevue '13, Waterbury
Green, W. F., Harvard '32, Newtown
Greenberg, A., L. I. Coll. Hosp. '32, Old Saybrook
Greenblatt, H. J., U. of Vermont '36, New Britain
Greenblatt, J., Louisiana '39, Stamford
Greene, G. G., Harvard '39, Rocky Hill
Greenhouse, B., Yale '21, New Haven
Greenspun, D. S., Yale '25, Bridgeport
Grenon, O. A., Georgetown '33, East Haven
Grevatt, K. L., Pennsylvania '35, Redding
Griffin, D. P., Jefferson '14, Bridgeport
Grigas, J. E., Tufts '36, Bethel
Griggs, J. B., Yale '26, West Hartford
Grillo, V. J., Yale '33, New York City (New Haven County)
Griswold, A. S., Yale '21, Bridgeport
Griswold, C., Yale '24, Bridgeport
Griswold, E. M., Yale '32, Glastonbury
Griswold, M., Yale '25, New Haven (New London County)
Griswold, M. H., Vermont '13, Hartford
Groark, J. A., Yale '24, New Haven
Groark, O. J., Med. Chi. Phila. '16, Bridgeport
Grodin, H. W., Yale '17, New Haven
Grossman, J. H., U. Rochester '41, Bridgeport (New Haven County)
Grossman, W., Berlin '21, Hartford
Grosvenor, F. L., Buffalo '00, Hartford
Grout, S. P., Vermont '04, Newtown
Grower, J. H., Nebraska '25, Middletown
Gudernatch, G. S., Cornell '39, Sharon
Gudger, J. R., Virginia '30, Hartford
Guida, F. P., Yale '34, New Haven
Gulash, J. R., Marquette '40, Bridgeport
Gulino, A. J., Tufts '31, Plainfield
Gura, G. M., Loyola '31, Southington
Gushee, E. S., Harvard '03, Wallingford
Guthrie,R. H., Tennessee '21, Norwich

Haberlin, C. E., Med. Coll. Va., '24 Stratford
Hale, F., P. & S., N. Y. '09, Bridgeport
Hale, V. A., Texas '22, Norwich
Haliday, E. G., Queen's '27, Stonington
Hall, L., Harvard '24, Hartford
Hall, M. I., Edinburg '34, Bristol
Hall, R. W., Yale '07, Bridgeport
Hall, W. C., Pennsylvania '30, Hartford
Hall, W. E., Yale '25, Meriden
Halloran, J. V., Boston U. '36, Greenwich
Hamilton, J. S. M., McGill '26, Stamford
Hanchett, H. B., Jefferson '05, Torrington
Hankin, M. A., L. I. Coll. Hosp. '33, New Haven
Hanley, J. P., Cornell '06, Stafford Springs
Hansen, P. S., Northwestern '38, Essex
Hanrahan, W. R., P. & S., Balt. '05, Bristol
Hardenbergh, D. B., Harvard '34, Bridgeport
Harper, P., Yale '31, Bridgeport
Harrington, A. T., Harvard '10, West Hartford
Harris, B. R., Yale '22, New Haven
Harris, J. S., Yale '32, New Haven
Harris, H. P., Jr., Duke '36, Fairfield
Harris, L. D., Tufts '34, Hartford
Harrison, E. R., Yale '26, New Haven
Harrison, F. M., Jefferson '22, Stamford
Harrison, J. F., Jefferson '03, Stamford
Harshbarger, I. L., Virginia '22, Bridgeport
Hart, C. J., Hahnemann '03, New Britain
Hart, J. C., Yale '30, New Haven
Hart, J. G., L. I. Coll. Hosp. '41, Westport
Hartman, F. B., Harvard '34, New London
Harty, J. E., Georgetown '37, Waterbury
Harvey, C. C., Cornell '16, Middletown
Harvey, D. F., Yale '33, Hartford
Harvey, E. R., Baltimore '09, Seymour
Harvey, J. LeR., Louisville '14, Waterbury
Harvey, S. C., Yale '11, New Haven
Harvey, T. S., Yale '41, Meriden
Hastings, L. P., Vermont '23, Hartford
Hathaway, J. S., Harvard '28, New Haven
Havey, L. A., Vermont '10, Bridgeport
Havill, R. A., U. Rochester '39, New Haven
Hawthorne, J., Tulane '20, Greenwich
Haylett, H. B., Vermont '07, East Hartford
Hazen, D. R., Harvard '33, West Hartford
Hazen, R., Vermont '98, Thomaston
Heafey, J. R., Syracuse '34, South Norwalk
Hebard, G. W., Cornell '36, New Canaan
Heinemann, M., Goettingen '25, New Haven
Hendel, I., Jefferson '17, New London
Henderson, A. C., P. & S., N. Y. '03, Stamford
Henderson, J., P. & S., N. Y. '31, Stamford
Hendricks, A. L., Yale '07, New Haven
Henkle, E. A., Cornell '99, New London
Henkle, R. T., Cornell '31, New London
Hennessey, E. H. J., Maryland '12, Stratford
Hennessey, J. G., Tufts '34, Bridgeport
Hennessy, J. J., P. & S., N. Y. '26, Hartford
Henze, C. W., Yale '00, New Haven
Hepburn, T. N., Johns Hopkins '05, Hartford
Herman, D. W., P. & S., N. Y. '24, Winsted
Herr, E. A., Vermont '09, Cheshire
Herrick, F. L., Vermont '31, New Haven (Litchfield County)
Herrmann, A. E., Harvard '23, Waterbury
Hersey, T. F., Tufts '37, MC-AUS (New Haven County)
Hertzberg, R. F., Harvard '26, Stamford
Hess, O. W., Buffalo '31, New Haven
Hetzel, J. L., Yale '26, Waterbury
Heublein, G. W., Yale 34, Hartford
Hewes, C. T., Vermont '31, Groton
Heyer, H. H., U. City N. Y. '87, New London
Heyman, J., Med. Coll. Va. '17, Hartford
Hickcox, C. B., Tufts '38, Hartford
Hiden, R. B., Virginia '23, New Canaan
Hieronymus, E. E., U. Louisville '33, Waterbury
Higgins, H. E., U. City N. Y. '96, Norwich
Higgins, H. W., Tufts '32, Norwich
Higgins, J. J., Georgetown '28, New Haven
Higgins, W. L., U. City N. Y. '90, South Coventry
Hill, E. R., Jefferson '24, Mystic
Hill, E. S., McGill '23, Torrington
Hill, W. E., Bowdoin '21, Naugatuck
Hillman, M. M., P. & S., N. Y. '19, New Haven
Hills, L. H., Wom. Med. Pa. '96, Winter Haven, Fla. (Windham County)

Hinchey, R. J., Tufts '21, Waterbury
Hippolitus, P. D., Yale '12, Bridgeport
Hirata, I., Yale '12, New Haven
Hirschfeld, O. M., Tufts '31, Hartford
Hirshberg, M. S., Tufts '27, Hartford
Hitchins, C. S., Cornell '38, New Haven
Hodgkins, C. H., Hahnemann '36, New Haven
Hodgson, T. C., Toronto '94, Berlin
Hoff, E. C., Oxford '28, New Haven
Hoffman, C. C., Buffalo '16, Hartford
Hogan, W. L., Vermont '18, Hartford
Holley, E., Albany '96, Brattleboro, Vt. (Middlesex County)
Hollinshead, J. B., Yale '37, West Hartford
Holt, K. R., Yale '26, Hartford
Holtz, R. S., Vermont '28, Hartford
Hooper, G. H., Boston '29, Bridgeport
Hopper, E. B., Yale '29, Stamford
Hopper, J. M., Chicago '40, Hartford
Horn, B., Univ. & Bellevue '29, Bridgeport
Horn, M. I., N. Y. Homeo. '15, Bridgeport
Horning, B. G., Harvard '28, Battle Creek, Mich. (Hartford County)
Horsefield, T. E., Vermont '29, Moodus
Hough, P. T., McGill '32, Hartford
Houle, R. T., Georgetown '32, East Hartford
Houze, H. G., Queens U. '24, Westport
Howard, A. J., Yale '20, New Haven
Howard, H. A., Tufts '29, Wethersfield
Howard, J. H., Georgetown '18, Bridgeport
Howard, L. A., Louisiana '39, Danbury
Howard, M. E., Johns Hopkins '31, New Haven
Howe, G. E., Harvard '18, Hartford
Howlett, K. S., Vanderbilt '31, Shelton
Hubert, G. R., Yale '35, Torrington
Hudon, F. A., Pennsylvania '37, Bristol
Hughson, D. T., Yale '27, New York City (New Haven County)
Hughson, F. G., Marquette '34, Madison
Humpage, N. W., Tufts '36, Winsted (Hartford County)
Hunkemeier, E., N. Y. U. '33, South Norwalk
Huntington, F. S., Harvard '24, Darien
Hurlburt, E. G., Vermont '35, Bridgeport
Hurwitz, G. H., Maryland '33, Hartford
Hurwitz, H. M., Yale '12, Hartford
Hutchison, J. E., Johns Hopkins '14, Hartford
Hyde, C. E., Yale '10, Bridgeport
Hyde, C. J., Univ. & Bellevue '03, Milford
Hymovich, L., Jefferson '29, Stamford
Hynes, F. H., Tufts '13, New Haven

Iannotti, J. P., U. of Naples '38, Bristol
Ignace, S. J., Georgetown '30, Derby (Litchfield County)
Ingram, H. D., Pittsburgh '27, Wilton
Inkster, J. H., Cornell '30, Ridgefield
Ireland, R. M., Vermont '31, New Milford (Fairfield County)
Irving, J. G., Toronto '32, Hartford
Irwin, H. H., Tufts '34, New London

Jack, G. J., Boston '07, New Haven
Jack, J. L., Yale '23, New Haven
Jackson, A. F., Howard '22, Hartford
Jackson, A. H., Yale '24, Washington
Jackson, A. J., P. & S., N. Y. '15, Waterbury
Jackson, E. B., Johns Hopkins '21, New Haven
Jackson, E. J., Tufts '19, Waterbury
Jacobson, A., Maryland '37, Portland
Jacobson, C. E., Jr., Cornell '35, Hartford
Jaffe, S. A., N. Y. U. '38, New Haven
Jaiven, S. J., N. Y. U. '40, Stamford
James, A. G. B., McGill '27, Bridgeport
James, G. R., Yale '10, Hamden
James, L. P., Yale '27, Hartford
January, D. A., Yale '34, Hartford
January, M. H., Yale '35, Hartford
Jarvis, H. G., Johns Hopkins '10, Hartford
Jenkins, R. H., Med. Coll. Va. '16, New Haven
Jennes, M. L., Tufts '38, Waterbury
Jennes, S. W., Tufts '34, Waterbury
Jenovese, J. F., Pennsylvania '30, Hartford
Johnson, A. A., P & S., N. Y. '17, Waterbury
Johnson, C. E., Harvard '26, New Haven
Johnson, H. A., Vermont '25, Watertown (New Haven County)
Johnson, P., Tufts '32, Hartford
Johnston, E. H., Maryland '00, Waterbury
Johnstone, K. T., Cincinnati, '34, Bridgeport
Jones, E. K., Columbia '34, Bridgeport
Jones, F. S., Yale '28, Hartford
Jordan, R. H., Virginia '33, New Haven
Joslin, G. H., Vermont '87, Hamden
Joyce, W. M., Jefferson '17, Middletown

Kahn, E., Munich '11, New Haven
Kalett, J., Jefferson '28, New Britain
Kalin, J. I., Harvard '24, Hartford
Kalman, E., Komensky, Czechoslovakia '23, Bridgeport
Kane, J. H., Md. Coll. Med. '04, Thomaston
Kaplan, L., Baylor '36, Bridgeport
Kaprielian, H. K., Virginia '08, Old Greenwich
Kardys, J. A., George Washington '30, Hartford
Karlin, F. L., St. Andrews '34, Waterbury
Karotkin, R. H., Univ. & Bellevue '32, Hartford
Kartin, B. L., Columbia '39, New Haven
Kaschmann, J., Munich '22, Hartford
Kaschub, R. W., Tufts '35, Groton
Katz, D., Vermont '25, Hartford
Katz, H., Harvard '21, Hartford
Katz, H. W. Tufts '40, New Haven
Katz, I., N. Y. Med. Coll. '37, Meriden
Katzenstein, R. E., Berne '38, Middletown
Katzman, S. S., Jefferson '21, Hartford
Kaufman, C., Jefferson '19, New London
Kaufman, W., Michigan '38, Bridgeport
Keating, J. J., Bellevue '34, New Milford (Fairfield County)
Keddy, R. A., McGill '24, Stamford
Keefe, G. G., Maryland '22, Hartford
Keefe, R. S., Boston '25, Hartford
Keefe, W. J., Maryland '31, Hartford
Keegan, D. F., Maryland '21, Bridgeport
Keeney, R. R., Jr., Tufts '34, Manchester
Keith, A. R., Harvard '03, Hartford
Kelemen, J., Budapest '25, Greenwich
Kelley, N. R., Harvard '37, Rocky Hill
Kellogg, H. K. W., P. & S., N. Y. '03, Norwalk
Kelly, C. C., Johns Hopkins '14, Hartford
Kelly, J. C. F., Queen's '28, Old Greenwich
Kelsey, W. M., Johns Hopkins '36, Westport
Kendall, R. E., Johns Hopkins '21, Hartford
Kennedy, C. S., Georgetown '30, Naugatuck
Kennedy, R. E., Yale '36, Newtown
Kennedy, W. C., Georgetown '10, Torrington
Kessler, F., U. Vienna '37, West Haven
Kettle, R. H., Queen's '28, Norwich
Keys, R. C., Kansas '27, Bridgeport
Kezel, A. P. C., Georgetown '35, Stamford
Kilbourn, A., Yale '23, Hartford
Kilbourn, J. B., P. & S., Balt. '11, Hartford
Kilgus, J. F., Maryland '31, Litchfield

Kingman, J. H., P. & S., N. Y. '85, New Haven (Middlesex County)
Kingsbury, I. W., P. & S., N. Y. '03, Hartford
Kinley, J. W., McGill '31, Newark, N. J. (Hartford County)
Kinney, K. K., Iowa '21, Willimantic
Kinsella, M. A., Tufts '12, New Britain
Kirby, S. B., Yale '28, New Haven
Kirschbaum, E. H., Yale '12, Waterbury
Klatskin, G., Cornell '33, New Haven
Klebanoff, H. E., Yale '25, New Haven
Klein, A. A., Louisville '29, Hartford
Klein, R. H., Women's Med. '40, West Hartford
Kleiner, S. B., Yale '15, New Haven
Klumpp, T. G., Harvard '28, New York City (New Haven County)
Knapp, C. S., P. & S., N. Y. '19, Greenwich
Knapp, C. W., P. & S., N. Y. '12, Greenwich
Knapp, R. P., P. & S., N. Y. '11, Manchester
Knauth, M. S., P. & S., N. Y., '23, Wilton
Kneale, H. B., Johns Hopkins '20, Bridgeport
Knepp, J. W., Richmond '05, Worcester, Mass. (Fairfield County)
Knobloch, H. R., N. Y. U. '40, New Haven
Knowlton, D. J., Harvard '12, Greenwich
Knowlton, M., Med. Coll. Ind. '05, Hartford
Koffler, A., Jefferson '34, Stamford
Koleshko, L. J., Maryland '42, Waterbury
Kornblut, A., Univ. & Bellevue '20, Bridgeport
Koster, L. W., N. Y. U. '37, West Haven
Kott, J. H., Bellevue '33, Torrington
Koufman, W. B., Tufts '35, New Haven
Kowalewski, V. A., Yale '02, West Haven
Krall, I. H., Long Island '37, Hartford
Kraszewski, H. W., Tufts '38, New Britain
Krinsky, C. M., Tufts '33, New London
Krochmal, H., Vienna '37, Meriden
Krosnick, G., Jefferson '38, New Haven
Krosnick, M. Y., Yale '30, New Haven
Kucewicz, W. J., St. Louis '36, Thompsonville
Kunkel, F. E., Yale '26, Hartford
Kushlan, S. D., Yale '35, New Haven

Laakso, A. O., Cornell '37, Danielson
La Bella, L. O., P. & S., N. Y., '25, Middletown
Labensky, A., Yale '21, New London
LaBrecque, F. C., Tufts '35, Waterbury
Labuz, E. F., Tufts '37, Bristol
Lacava, J. J., Georgetown '34, New Britain
Lambert, H. B., Jefferson '09, Bridgeport
LaMoure, C. TenE., Albany '94, Windham Center (Tolland County)
Lamoureux, E. E., Tufts '35, Hartford
Lampson, E. R., P. & S., N. Y. '96, Hartford
Lampson, R. S., Harvard '34, Hartford
Landecker, N., Friedrich Wilhelm U. '26, Bridgeport
Landry, A. B., Jefferson '09, Hartford
Landry, B. B., Harvard '20, Hartford
Lang, W. P., Hahnemann '01, North Haven
Langner, H. P., Yale '22, Milford
Lankin, J. J., Harvard '37, Hartford
LaPalme, J. A., Tufts '25, Webster, Mass. (Windham County)
Lapenta, R. G., George Washington '37, Hartford
LaPlume, A. A., Montreal '24, Bristol
Larimore, L. D., Wom. Med. Pa. '15, Greenwich
Larkin, C. L., Yale '15, Waterbury
Larrabee, J. W., Harvard '26, Hartford
Laszlo, A. E., Kiel '23, Bridgeport
LaTaif, C. G., Hahnemann '36, Danbury (Litchfield County)
Latimer, M. L., Vanderbilt '32, New Haven
Laube, P. J., Iowa '36, New Haven
Lavietes, P. H., Yale '30, New Haven
Lawlor, M. J., P. & S., N. Y. '06, Waterbury
Lawrence, E. A., Western Reserve '35, Hamden
Lawson, S. J., Virginia '05, New London
Lawton, R. J., Md. Coll. Med. '08, Terryville
Lay, W. S., Yale '01, Hamden
Leak, R. L., Albany '98, West Hartford
Lear, M., Yale '11, New Haven
Leary, D. C., Yale '36, Hartford
Leddy, P. A., Harvard '24, New Haven
Lee, F. N., Kansas '23, Milford
Lee, J. R., Queen's '24, Devon
Lehman, E. B., Tennessee '28, New Haven
Lehndorff, P., Vienna '37, New Haven
Lekston, R. F., Med. Chi., Phila. '15, New Britain
Lena, H. F., Johns Hopkins '16, New London
Lencz, E., U. Vienna '36, Shelton (New Haven County)
Lenehan, J. R., Jefferson '37, Hartford
Lengyel, P., Budapest '31, Bridgeport
Lenkowski, W. J., N. Y. U. '37, Waterbury
Lennox, M. A., Yale '39, New Haven
Leonard, J. C., Yale '32, Melrose, Mass. (Hartford County)
Leonard, G. A., Md. Coll. Med. '05, Waterbury
Leonard, M., Yale '31, New Haven
Leonard, R. J., Georgetown '38, Mansfield Depot
Lepreau, F. J., Jr., Harvard '38, New Haven
Lesko, J. M., Duke '38, Bridgeport
Levenson, A., Tufts '22, Bridgeport
Leverty, C. J., Univ. & Bellevue '01, Bridgeport
Levin, A. E., Tufts '30, Hartford
Levin, C. A., Johns Hopkins '20, Hartford
Levin, H. A., Univ. & Bellevue '18, New Haven
Levine, L. W., Maryland '37, Ellington
Levine, S. S., P. & S., Balt. '12, Hartford
Levinsky, M., Maryland '28, Bridgeport
Levy, A., Tufts '31, Winsted
Levy, D. F., Yale '19, New Haven
Levy, M. N., Tufts '23, Bridgeport
Levy, N., Yale '27, Branford
Levy, S. H., Tufts '35, Stratford
Levy, W., Yale '11, Suffield
Lewicki, E. S., Georgetown '35, Waterbury
Lewis, D. M., Johns Hopkins '01, New Haven
Lewis, F., Long Island '36, Stamford
Lewis, R. M., Pennsylvania '10, New Haven
Lewis, S. D., George Washington '31, Elmwood
L'Heureux, J. A., Boston '34, Meriden
Lieberman, D. L., N. Y. U. '26, Chester
Lieberthal, M. M., N. Y. U. '35, Bridgeport
Liebow, A. A., Yale '35, Meriden
Linde, J. I., Yale '08, New Haven
Lindsay, M. K., P. & S., N. Y. '10, Bethesda, Md. (New Haven County)
Lindsay, M. S., Tufts '11, Middletown
Lindskog, G. E., Harvard '28, New Haven
Lirot, S. L. R., McGill '32, Meriden
Lischner, M. D., Yale '30, Hartford
Little, H. C., Yale '10, New Haven
Little, M. F., Yale '28, Hartford
Little, M. H., Harvard '35, Fairfield
Little, O. A. G., Boston '35, Bridgeport
Littwin, R. J., L. I. Coll. Hosp. '36, Bristol
Lobb, R. A., Hahnemann '37, Deep River
Locke, H. L. F., Tufts '12, Hartford
Lockhart, R. H., Yale '28, Bridgeport
Lockwood, H. DeF., Yale '01, Meriden
Lockwood, J., Johns Hopkins '30, Greenwich

Lockwood, J. S., Harvard '31, New Haven
Loffredo, L., Pennsylvania '22, Middletown
Logan, W. J., Yale '25, New Haven
Loiacono, A. J., Harvard '27, New London
Lolli, G., Rome '28, New Haven
Lombardi, P. F., Tufts '21, Waterbury
Lopatin, C., Louisville '41, New Haven
LoRusso, D. L., Marquette '34, Torrington
Loveland, E. K., Yale '97, Watertown
LoVetere, A. A., George Washington '35, New Britain
Lowell, W. H., Jr., Harvard '37, Hartford
Lowman, R. M., Maryland '36, New Haven
Lubchansky, J. H., Bellevue '33, Uncasville
Lublin, R. D., Johns Hopkins '29, East Hartford
Luby, T. J., McGill '14, Hartford
Luckner, W. G., Jefferson '38, Stafford Springs
Ludlow, G. C., Harvard '19, New Canaan
Lukoski, W. A., Georgetown '32, Norwich
Lund, F. A., N. Y. Med. '00, Orlando, Florida (New London County)
Lundberg, G. A. F., Jefferson, '19, South Manchester
Lundborg, F. L., Yale '30, West Hartford
Lutz, W. G., U. Munich '36, New Haven
Lyman, D. R., Virginia '99, Wallingford
Lynch, E. J., Pennsylvania '09, Shelton
Lynch, H., N. Y. U. '24, Bridgeport
Lynch, J. C., U. City N. Y. '86, Bridgeport
Lynch, R. J., Bellevue '97, Bridgeport
Lyon, G. A., Cornell '41, Bridgeport

MacCready, P. B., Johns Hopkins '21, New Haven
MacCready, W. H., Harvard '27, Windsor
Mackay, W. D., Indiana State '28, Sharon
MacLean, D. R., Maryland '01, New Haven (Fairfield County)
MacLean, E. M., McGill '30, Farmington
MacLeod, E. A., Wom. Med. Pa. '25, Niantic
Madden, L. I., Harvard '10, Hartford
Magnano, J., Yale '27, Middletown
Maher, J. R., Boston '27, Stratford
Mahoney, D. F. C., Georgetown '24, Redlands, Calif. (Hartford County)
Mahoney, J. J., McGill '33, Norwich
Maine, T. P., Med. Chi. Phila. '12, Mystic
Maislen, S., Vermont '14, Hartford
Malloy, E. F., Cornell '28, Stamford
Mancoll, M. M., Jefferson '28, Hartford
Manwaring, I. J., Pennsylvania '95, Norwich
Marglis, B., Bowdoin '20, Bridgeport
Margolick, M., McGill '35, Putnam
Margolius, N., Cornell '33, Waterbury
Marinaro, N. A., St. Louis '30, Hartford
Markle, R. D., Syracuse '37, North Woodbury
Markoff, K. K., Vermont '19, Norwich
Markwald, H. W., Berlin '37, Torrington
Marranzini, S., Univ. & Bellevue '28, Hartford
Marsh, A. D., Yale '08, Hampton
Marshall, C. L., Howard '24, New Haven
Martin, J. G., Yale '33, West Hartford
Martin, J. S., Yale '05, Watertown
Martin, R. A., Vermont '37, Bridgeport
Marvin, H. M., Harvard '18, New Haven
Maslak, R., Louisville '34, Warehouse Point
Massa, A. F., Yale '18, New Haven
Massey, D. M., Hahnemann '36, Bridgeport
Mastroianni, L., Padua '17, New Haven
Mathews, F. P., Harvard '30, Vashon, Washington (Fairfield County)
Matteis, J. T., Yale '26, New Britain
Maurer, L. L., Yale '16, New Haven
Maxwell, J. A., Med. Coll. Va. '17, Bridgeport
Maynard, H. H., Yale '16, New Haven
Mayo, E. R., Tufts '38, Waterbury
McAlenney, P. F., Yale '29, New Haven
McCabe, E. J., Yale '26, New Haven
McClellan, W. E., Toronto '04, Hartford
McCombs, A. P., Cornell '29, Wilton
McCook, J. B., P. & S., N. Y., '94, Hartford
McCormack, C. J., Yale '29, Hartford
McCrann, D. J., Tufts '34, Hartford
McCreery, J. A., P. & S., N. Y. '10, Greenwich
McCue, M. P., Harvard '34, East Hartford
McDermott, J. F., Cornell '23, Hartford
McDonnell, R. E., Yale '20, New Haven
McFarland, F. W., Vermont '28, Stamford
McGaughey, J. D., Jefferson '10, Wallingford
McGourty, A. F., N. Y. Homeo. '18, Stamford
McGourty, D. P., Jefferson '27, Stamford
McGovern, E. F., Univ. & Bellevue '01, Bridgeport
McGrath, J. F., McGill '23, Hartford
McGrath, J. H., Yale '08, Waterbury
McGuire, F. J., Boston '37, Guilford
McGuire, W. C., Yale '09, New Haven
McHugh, J. F., Harvard '01, Thompsonville
McIntosh, E. F., Yale '97, New Haven
McKeon, J. J., Hahnemann '39, Hamden
McLarney, T. J., P. & S., Balt. '97, Hartford (New Haven County)
McLaughlin, J. H., P. & S., Balt. '09, Jewett City
McLean, J. J., Tufts '20, Hartford
McLean, T. S., Jr., Vermont '34, Bridgeport
McLellan, P. G., Harvard '25, Hartford
McLeod, C. E., Vermont '34, Middletown
McMahon, F. C., Fordham '19, Stamford
McMahon, G. W., Tufts '37, New Britain
McMahon, J. D., Creighton '37, South Norwalk
McMahon, W. H., Jr., Fordham '20, South Norwalk
McNamara, W. J., Vermont '29, New Haven
McNulty, T. F., Georgetown '32, Hartford
McPartland, C. E., Johns Hopkins '23, West Hartford
McPherson, S. H., Tufts '13, Hartford
McQueen, A. S., Yale '01, Branford
McQueeney, A. M., Yale '05, Bridgeport
Meeker, D. O., Rochester '29, Cos Cob
Mekrut, J. A., St. Louis '31, Meriden
Mendelsohn, W., Johns Hopkins '33, New Haven
Mendillo, A. J., Yale '07, New Haven
Mendillo, J. C. F., Yale '30, New Haven
Menousek, J. A., Vermont '32, Plainville
Meo, R. C., George Washington '34, Waterbury
Merrill, W. T., Dartmouth '90, East Milton, Mass. (New Haven County)
Merriman, H., P. & S., N. Y. '36, New Haven
Merriman, M. H., P. & S., N. Y. '06, Waterbury
Meschter, E. F., Med. Chi. Phila. '98, Stamford
Metcalf, E. H., Jefferson '14, Rockville
Meyer, F. M., Indiana '28, Bridgeport
Meyers, R. A., Michigan '31, Watertown
Michalowski, V. S., Boston '29, New Britain
Middlebrook, L. F., Jr., Johns Hopkins '30, Hartford
Mignone, J., Yale '33, New Haven
Milano, N. A., Georgetown '27, West Haven
Miles, H. S., P. & S., N. Y. '91, Bridgeport
Millen, S. R., George Washington '38 Rocky Hill (New Haven County)
Miller, H. B., Rush '33, New Britain
Miller, H. C., Yale '34, Kansas City, Mo. (New Haven County)

Miller, J., Cornell '15, Norwalk
Miller, J. R., Johns Hopkins '11, Hartford
Mills, B. L., Vermont '25, Meriden
Minor, L. W., Yale '32, Middletown
Mirabile, C. S., McGill '30, Hartford
Mirabile, T. J., Georgetown '37, East Hartford
Misuk, J. F., Georgetown '32, Meriden
Mitchell, G. V., McGill '38, Bridgeport
Mogil, M., Buffalo '39, New Haven
Moise, T. S., Johns Hopkins '17, Hartford
Monacella, J. M., P. & S., N. Y. '35, Windsor
Monahan, D. T., Yale '33, Bridgeport
Mongillo, F., Med. Coll. Va. '28, New Haven
Montano, C. C., Tufts '35, Hartford
Montano, R. A., Tufts '33, Hartford
Mooney, S., Tufts '27, Bridgeport
Moorad, P. J., Rochester '31, New Britain
Moore, C. D., Queen's '28, Newtown
Moore, D. B., Tufts '35, New Haven
Moore, D. DeC. Y., N. Y. Homeo. '95, South Manchester
Moore, G. E., Yale '34, Darien
Moore, H. D., Hahnemann '93, Danbury
Moore, H. F., Missouri '98, Bethel
Moore, M. R., Queen's '29, Norwich
Moore, W. J., P. & S., N. Y. '21, Cheshire
Moran, J. P., Maryland '36, New London
Morgan, K. R., Yale '42, New Haven
Morgan, W. O., Georgetown '30, Westport
Moriarity, J. L., Harvard '96, Waterbury
Moriarty, M. E., Yale '26, South Manchester
Morrill, H. F., Harvard '25, Waterbury
Morris, J. S., Texas '27, New London
Morriss, W. H., Johns Hopkins '12, Wallingford
Morrissett, L. E., Med. Coll. of Virginia '36, Greenwich
Morrissey, M. J., P. & S., Balt. '97, Hartford
Morse, A. H., Johns Hopkins, '06, New Haven
Morse, L. R., Queen's '26, Hartford
Morse, W. J., Vermont '31, New London
Moser, O. A., Yale '02, Rocky Hill
Mott, F. E., U. Buffalo '41, New Haven
Mouradian, M. G., Wom. Med. Pa. '13, New Britain
Moxness, B. A., Georgetown '25, Hartford
Moylan, T. P., Buffalo '22, Hartford
Moyle, H. B., Toronto '10, Hartford
Mozzer, A. J., Hahnemann '38, Middletown
Mucci, L. A., Rochester '34, New Britain (New Haven County)
Mullen, J. J., Tufts '29, Waterbury
Mullins, S. F., Univ. & Bellevue '06, Danbury
Mulville, M. F., Tufts '37, Hartford
Murcko, W. J., Marquette '37, Torrington
Murdock, T. P., Baltimore '10, Meriden
Murphy, C. A., L. I. Coll. Hosp. '33, Stamford
Murphy, J., Pennsylvania '95, Middletown
Murphy, J. J., Georgetown '35, Danbury
Murphy, O. L., Vermont '21, Simsbury
Murphy, T. B., Harvard '23, Wallingford
Murphy, T. D., P. & S., N. Y. '30, West Ha[illegible]
Murphy, T. F., Jefferson '33, Hartford
Murray, H. J., Jefferson '16, Stamford
Murray, T. J., Maryland '10, New London
Murray, T. O., Tufts '32, Danbury
Murray, W. J., Jefferson '32, Bridgeport
Musselman, L. K., Johns Hopkins '19, New Haven
Mylon, E., Munich, Berlin '20, New Haven

[illegible]agle, W. T., Med. Chi. Phila. '14, Southington
[illegible]ahum, L. H., Yale '16, New Haven
Narowski, J. J., Tufts '43, Derby
Naylor, J. H., Vermont '95, Hartford
Neff, W. E., Jr., P. & S., N. Y., '33, Cheshire
Neidlinger, W. J., Cornell '33, Hartford
Nelson, R. B., Cornell '34, Waterbury
Nelson, W. N., George Washington '26, Cromwell
Nemoitin, B. O., L. I. Coll. Hosp. '34, Stamford
Nemoitin, J., P. & S., N. Y. '05, Stamford
Nesbit, R. R., Albany '29, New Haven
Nesbitt, S., Harvard '35, New Haven
Nespeco, J. V., Georgetown '32, Bridgeport
Nespor, R. W., Boston '33, Westport
Nestos, P. A., Rush '14, Bristol
Nettleton, I. LaF., L. I. Coll. Hosp. '98, Bridgeport
Neumann, H. A., L. I. Coll. Hosp. '09, Bridgeport
Neumann, V. F., Michigan '29, Norwich
Neuswanger, C. H., Harvard '23, Waterbury
Nevulis, A. V., Vermont '38, New Britain
Newman, J. T., Yale '19, New Haven
Newton, L., N. Y. Homeo. '31, Bridgeport
Nichols, C. W., Vermont '20, Bridgeport
Nichols, R. W., Johns Hopkins '12, New Haven
Nickum, J. S., Tufts '18, Bridgeport
Nodelman, J., Yale '29, New Haven
Nolan, J. F., McGill '32, Bridgeport
Northrop, R. A., Jefferson '32, Norwalk
Nyboer, J., Michigan '35, Hartford

Oberg, F. T., Harvard '16, Bridgeport
O'Brasky, L., Jefferson '22, New Haven
O'Brien, H. R., Michigan '19, Hartford
O'Brien, J. F., Yale '08, Waterford
O'Brien, W. H. J., Yale '12, New Haven
O'Connell, E. J., Tufts '34, Unionville
O'Connell, J. D., Harvard '39, Hartford
O'Connell, J. F., Vermont '21, Hartford
O'Connell, J. G., Tufts '17, Bridgeport
O'Connell, M. F., Yale '22, Hartford
O'Connell, P. H., Loyola '29, Norwich
O'Connell, W. M., Yale '17, West Haven
O'Connor, D. S., Bowdoin '19, New Haven
O'Donnell, T. J., Syracuse '08, Greenwich
Oelschlegel, H. C., Jefferson, '11, Torrington
Oesau, H. T., Jefferson '26, Stratford
O'Flaherty, E. P., Cornell '01, Hartford
Ogden, R. T., Harvard '24, Hartford
Olmsted, J. G. M., McGill '25, Hartford
O'Loughlin, T. F., U. City N. Y. '96, Rockville
Oltman, J. E., Minnesota '34, Newtown
O'Meara, F. P., N. Y. Med. Coll. '36, Glenbrook
Onderdonk, H. J., N. Y. U. '97, East Hartford
O'Neil, M. L., Yale '29, Jewett City
O'Neill, C. W., Yale '26, Hartford
O'Neill, John J., Tufts '32, Bridgeport
Oppenheimer, K., Heidelberg '20, Norwich
Opper, L., Munich '33, Norwich
Orbach, E. J., Friedrich Wilhelm Univ., Berlin '24, New Britain
Orlowski, A. W., Tufts '36, Rockville (Litchfield County)
Oros, L. M., Budapest '37, Bridgeport
Osborn, S. H., Tufts '14, Hartford
Osgood, C., P. & S., N. Y. '03, Norwich
Osmond, R. H., Yale '23, Hartford
Oster, K. A., Cologne '34, Bridgeport
Otis, F. N., Tufts '18, Meriden
Otis, I. S., George Washington '17, Meriden
Ottenheimer, E. J., Virginia '22, Willimantic
Oughterson, A. W., Harvard '29, New Haven
Owen, P. S., Yale '37, Chester
Oxnard, E. W., Harvard '36, Cheshire

Padula, R. D., Cincinnati '30, Norwalk
Padula, V. D., Rome '35, Hartford
Pagliaro, J. J., Georgetown '37, Shelton
Paine, R. C., Dartmouth '00, Thompson
Palmieri, M. L., Yale '32, Middletown
Palmieri, M. W., Naples '33, New Haven
Panettieri, A. J., Vermont '37, Bridgeport
Paolillo, C. G., Yale '35, New Britain
Papa, J. S., Tufts '28, Bristol
Parente, L., Emory '31, Hamden
Paris, M., N. Y. U. '30, South Norwalk
Park, P. A., Iowa Homeo. '10, Bristol
Parker, J. W., Yale '06, Hartford
Parker, R. L., Western Ontario '41, New York City (Fairfield County)
Parlato, H. A., N. Y. U. '36, New Britain
Parlato, M. A., Yale '08, Derby
Parmelee, B. M., Vermont '19, Bridgeport
Parmelee, E. K., L. I. Coll. Hosp. '89, Ansonia
Parrella, L. A., Tufts '34, North Haven
Parshley, P. F., Pennsylvania '27, West Hartford
Partridge, W. P., Harvard '20, Hartford
Pascal, T. J., Rush '31, Bridgeport
Pasetto, E., Vermont '36, Waterbury
Pasquariello, D. W., Naples '36, Bridgeport
Patterson, D. C., P. & S., Balt. '06, Bridgeport
Patterson, F. A., Harvard '27, Norwalk
Paul, F., Ludwig-Maximilians-Universitat Medizinicshe Fakultat '24, Greens Farms
Paul, J. R., Johns Hopkins '19, New Haven
Paul, V. A., Hahnemann, Chicago '13, Stamford
Peacock, A. U., Rush, '33, Hartford
Peck, B. C., Long Island '31, New Britain
Peck, R. E., Yale '93, Concord, New Hampshire (New Haven County)
Pelliccia, O., Jr., Johns Hopkins '39, New Haven
Peltz, W. L., Harvard '36, New Haven
Pelz, K., Austria '32, Wallingford
Pendleton, C. E., Yale '03, Colchester
Pendleton, E. R., P. & S., Boston '04, Granby
Penner, S. L., P. & S., N. Y., '34, Stratford
Pennington, H. F., Harvard '27, Meriden
Pepe, A. J., Maryland '35, Norwich
Perakos, G. P., Georgetown '32, New Britain
Perdue, R. E., Starling '95, Norwalk
Perham, W. S., Michigan '32, Woodbridge
Perkins, C. W., Hahnemann '01, Norwalk
Perkins, J. A., McGill '41, Hartford
Perreault, J. N., Tufts '07, Danielson
Perrins, H. B., Yale '18, New Haven
Perry, M. J., Wom. Med. Homeo. N. Y. '03, Norwalk
Peters, J. P., P. & S., N. Y. '13, New Haven
Peterson, C. K., Tufts '05, Lakeville
Petrelli, J., Yale '25, New Haven
Petrucelli R. J., P. & S., N. Y. '34, Meriden
Pharris, C., U. of Tennessee '29, East Hartford
Phelps, M. O., McGill '29, Hartford
Phelps, P. S., McGill '30, Hartford
Philipson, S., N. Y. Homeo. '18, New Haven
Phillips, F. L., Yale '06, New Haven
Phillips, H. S., Toronto '22, Westport
Phillips, K. T., Tufts '19, Putnam
Phillips, P. L., Cornell '30, Norfolk, Va. (Hartford County)
Piasecki, J. L., Maryland '12, Norwalk
Piasta, P. F., Boston '24, Middletown
Piazza, G. J., Boston '32, New Haven
Piccolo, P. A., Maryland '37, New Haven
Pierson, E. M., Yale '24, Cromwell
Pierson, L. A., Tufts '27, Meriden
Pike, E. R., Michigan '98, East Woodstock
Pike, M. M., Harvard '25, Hartford
Pileggi, P., Maryland '28, Bridgeport
Pinn, A. S., Laval '29, New Haven
Pitegoff, C. H., St. Louis '40, East Hartford
Pitegoff, G. I., St. Louis '37, Hartford
Pitock, M. P. Tufts '30, Fairfield
Platt, I. S., Southern California '12, Waterbury
Platt, W. L., P. & S., N. Y. '81, Newtown (Litchfield County)
Plukas, J. M., Georgetown '32, Bridgeport
Pola, W. E., Louisville '32, New Britain
Polito, F. L., Yale '21, Torrington
Pollard, R. L., Tufts '36, Waterbury
Pomeroy, N. A., P. & S., N. Y. '96, Waterbury
Poole, A. K., Johns Hopkins '23, New Haven
Popkin, M. S., George Washington '35, Bridgeport
Post, E. A., Georgetown '33, Waterbury
Poverman, D., Vermont '32, New Haven
Powell, W., Queen's '24, New Haven
Powers, G. F., Johns Hopkins '13, New Haven
Pratt, A. M., Bellevue '92, Deep River
Pratt, A. P., Harvard '22, Windsor
Pratt, E., P. & S., N. Y. '87, Torrington
Pratt, G. K., Detroit '15, Bridgeport
Pratt, N. T., Yale '04, Old Saybrook (Fairfield County)
Preston, T. R., Yale '25, Hartford
Priddy, F. E., Northwestern '28, Hartford
Prior, J. D., Toronto '28, Waterbury
Prosser, F. D., Cornell '28, Putnam
Prout, E. B., Syracuse '14, Portland
Pullen, R. W., Yale '21, New Britain
Purinton, C. O., Yale '00, Sunmount, N. Y. (Hartford County)
Pyle, E., P. & S., N. Y. '15, Waterbury

Quatrano, J. C., Vermont '31, Bridgeport
Quarrier, S. S., P. & S., N. Y. '32, Hartford
Quinlan, R. V., Baltimore '10, Meriden
Quinn, J. F., Baltimore '06, Bridgeport
Quinn, K. S., Temple '35, Bridgeport
Quinn, R. J., P. & S., Balt. '13, Waterbury
Quintiliani, A., Harvard '29, Norwich

Rabinovitch, A., Vermont '19, Norwich
Rademacher, E. S., Iowa '23, New Haven
Radin, M. J., P. & S., N. Y., '16, Hartford
Radom, M. M., Jefferson '25, Hartford
Raffa, J., P. & S., N. Y. '34, Glastonbury
Rafferty, B., Jefferson '28, Willimantic
Rafkind, A. B., Paris '37, Middletown
Rand, R. F., Johns Hopkins '00, New Haven
Randall, W. S., P. & S., N. Y. '86, Shelton
Rankin, B. F., McGill '19, Hartford
Rapp, A. G., Cornell '29, New London
Rasmussen, H. N., Tufts '25, Uncasville
Rawls, E. C., Med. Coll. Va. '31, Stamford
Raymer, J. G., Harvard '25, Norwich
Raynolds, R., P. & S., N. Y. '14, New Haven (New London County)
Read, F. A., Yale '34, Old Greenwich
Reade, E. G., Jefferson '16, Watertown
Reardon, W. F., Baltimore '04, Hartford
Redlich, F. C., U. Vienna '35, New Haven
Reich, U. S., Virginia '09, Bridgeport
Reichenbach, A. E., Tufts '38, Waterbury
Reid, L. R., Pennsylvania '33, Norwich (Fairfield County)
Reidy, D. D., P. & S., N. Y. '27, Hartford
Reidy, M. J., P. & S., N. Y. '10, Winsted
Reilly, W. J., Tufts '35, Naugatuck

Reiter, B. R., Harvard '34, Bridgeport
Renehan, J. M., Tufts '28, Ansonia
Rentsch, S. B., Michigan '23, Derby
Resnik, E., McGill '30, New Britain
Resnik, H., Johns Hopkins '31, Bridgeport
Resnik, W. H., Johns Hopkins '21, Stamford
Resnisky, A. F., Georgetown '23, Hartford
Reynolds, H. St. C., Yale '10, Hartford
Reynolds, H. S., Albany '14, Hartford
Reynolds, J. A., Tufts '36, Waterbury
Reynolds, R. G., Harvard '26, Hartford
Reynolds, W. M., P. & S., N. Y. '31, Greenwich
Ribner, H., Tufts '34, Bridgeport
Riccio, J. S., St. Louis '37, New Haven
Riccitelli, M. L., Yale '22, New Haven
Richardson, R. A., Vermont '14, Bristol
Richter, H. G., Yale '31, Narbeth, Pa. (New Haven County)
Riendeau, F. M., Paris '27, Torrington
Riendeau, P. L., Paris '27, Torrington
Rilance, A. B., McGill '31, New Haven
Rindge, M. E., Duke '41, Madison
Rindge, M. P., P. & S., Cleveland '05, Madison
Rindge, N. P., Yale '35, Clinton
Riordan, M. D., Vermont '12, Willimantic
Robbins, B. B., U. City N. Y. '94, Bristol
Robbins, C. L., Yale '29, New Haven
Roberge, G. E., Yale '38, Stratford
Roberts, D. J., Vermont '16, Hartford
Roberts, E. R., Maine '13, Bridgeport
Roberts, F. W., Johns Hopkins '24, New Haven
Robey, Nathaniel C., Yale '17, Newtown
Robinson, A. J., Toronto '23, Hartford
Robinson, W. J. T., L. I. Coll. Hosp. '21, Broad Brook
Robison, R. C., Yale '36, New Canaan
Roccapriore, B. A., Jefferson '31, Middletown
Rocco, M. P., Georgetown '41, Hartford
Roch, G. E., Tufts '34, Willimantic
Roche, A. F., Georgetown '17, Hartford
Roche, T. J., P. & S. Balt. '11, Bridgeport
Rockwell, A. E., Johns Hopkins '21, Bridgeport
Rogawski, A. S., Vienna '38, Waterbury
Rogers, F. P., Syracuse '33, West Hartford
Rogers, O. F., Jr., Harvard '12, New Haven
Rogers, P. H., Yale '12, West Haven
Rogers, R. P., Harvard '25, Greenwich
Rogol, L., L. I. Coll. Hosp. '33, Danbury
Rogol, O., Dalhousie '32, Seymour
Rogowski, B. A., Yale '24, New Haven
Rollins, H. B., Yale '22, Hartford
Romaniello, R. J., P. & S., N. Y. '27, Hartford
Rooney, J. F., Baltimore '03, Hartford
Root, J. H., Harvard '18, Waterbury
Root, M. T., Cornell '18, West Hartford
Root, S. A., Cornell '19, West Hartford
Rosahn, P. D., N. Y. U. '28, New Britain
Rose, S. A., Univ. & Bellevue '23, Stamford
Rosenbaum, G. J., Tufts '34, Hartford
Rosenberg, H. A., Vienna '37, Bridgeport
Rosenthal, E., Wurtenberg & Munich '24, Hartford
Rosenthal, I., L. I. Coll. Hosp. '10, South Norwalk
Ross, A. M., Basel '35, Darien
Roth, F. E., Univ. & Bellevue '25, Hartford
Roth, O., Vienna '37, New Haven
Roth, S. Z., Vienna '36, New Haven
Rothblatt, R., Harvard '37, Willimantic
Rothschild, M. L., Paris '26, New Haven
Rowell, E. E., Hahnemann '99, Stamford
Rowley, J. C., Harvard '06, West Hartford
Rowley, R. L., Yale '03, Hartford
Roy, J. L., Tufts '34, North Grosvenordale
Rozen, A. A., Yale '37, New Haven
Rubin, G. A., Edinburgh '32, New Haven
Ruby, M. H., P. & S., N. Y. '21, Waterbury
Ruby, R. J., Baylor '36, Waterbury
Russell, G. G., Harvard '19, Hartford
Russell, J. J., N. Y. Homeo. '87, Putnam
Russell, T. H., Yale '10, New Haven
Russell, W. I., Yale '09, New Haven
Russman, C., Tufts '23, Middletown
Russo, J. D., Yale '16, New Haven
Ryan, A. J., P. & S., N. Y. '40, Brooklyn, New York (New Haven County)
Ryan, F. J., Tufts '35, Ft. Howard, Md. (Hartford County)
Ryan, V. G., Yale '34, Portland
Ryder, C. F., Western Reserve '33, Stamford
Ryder, R. H., P. & S., Balt. '13, Waterbury
Ryder, W. H., Jefferson '20, New Haven
Ryley, R. N., Yale '39, Mystic
Rynard, W. M. W., Toronto '24, Stamford

Sabloff, J., L. I. Coll. Hosp. '34, New London
Sadusk, J. F., Jr., Johns Hopkins '35, New Haven
St. John, L. A., Fordham '20, Hartford
Salinger, R., Johns Hopkins '25, New Haven
Salter, W. T., Harvard '25, New Haven
Saltzman, J. A., N. Y. Homeo. '33, Waterbury
Salvin, B. L., George Washington '21, Hartford
Samponaro, N., Johns Hopkins '29, Hartford
Sanderson, R. V., Vermont '20, Winsted
Sandulli, G. R., Tufts '29, Waterbury
Sanford, C. E., Yale '06, New Haven
Santoro, G. M., Cornell '24, Waterbury
Satti, C. J., Yale '23, New London
Savage, P. J., Maryland '21, New London
Savarese, M. F. R., L. I. Coll. Hosp. '11, New Haven
Sayers, D. O'C., Tufts '35, Waterbury
Sayers, J. J., Tufts '35, Hartford
Scafarello, P. J., Tufts '26, Hartford
Scalzi, L. C., Bologna '37, Bridgeport
Scanlon, J. J., Georgetown '35, Norwalk
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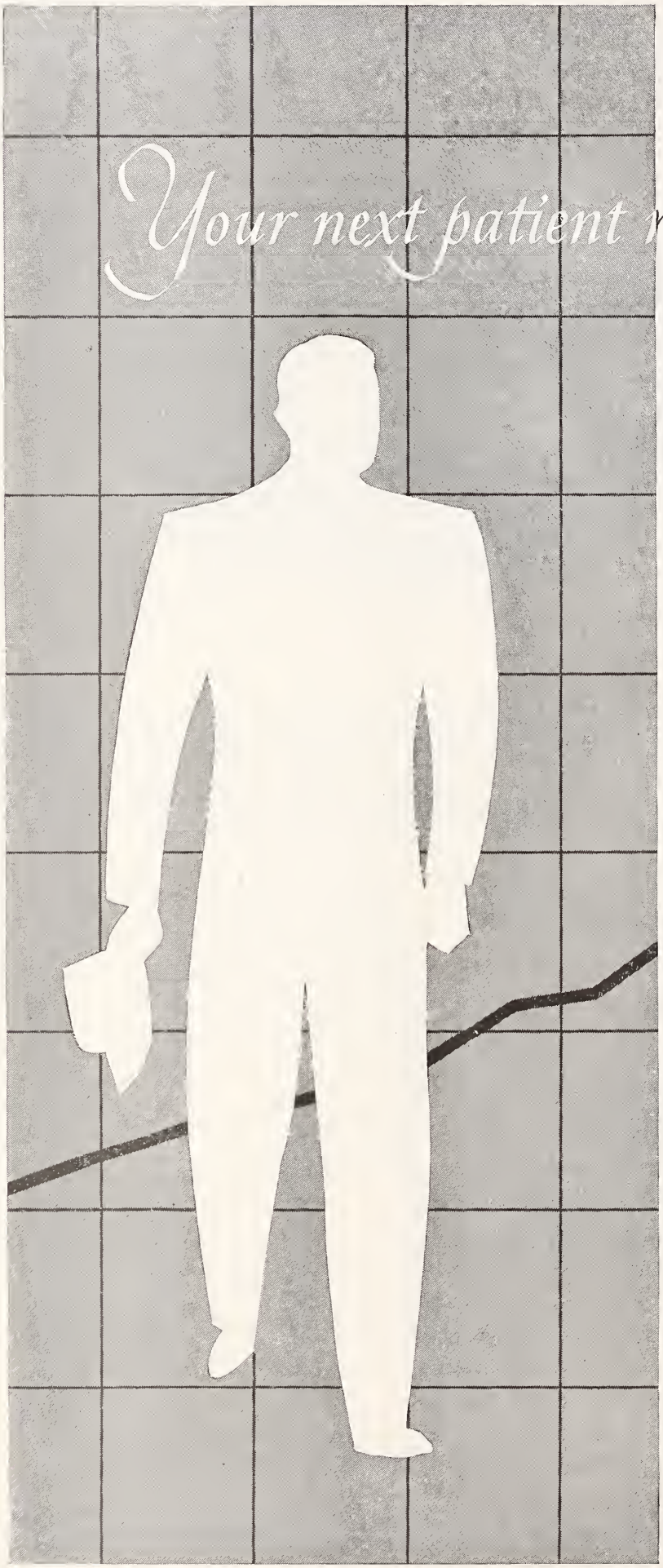
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# Your next patient may be diabetic

A REVIEW of the records of over 45,000 selectees by Blotner and Hyde* reveals an incidence of diabetes among young adults much greater than earlier studies have indicated. In the eighteen to twenty-five-year age group, the number of cases was found to be three to four times as high as shown in the National Health Survey. In men of twenty-five to forty-five years, diabetes occurred four to five times as often as in the previous estimate. Another striking fact—78 percent of the cases thus discovered were not aware of ever having had diabetes!

While the question of the actual incidence of diabetes cannot be answered with accuracy, physicians are alert to the unmistakable upward trend. A routine qualitative urine-sugar test on every patient is becoming an increasingly important procedure. Only through unrelaxed vigilance may early and adequate treatment be made available to the patient before important complications develop.

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*Blotner, H., and Hyde, R. W.: New England J. Med., 229:885, 1943.

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VOL. IX SEPTEMBER, 1945 No. 9

# SOME RECENT ADVANCES IN THE CONTROL OF INFECTIOUS DISEASES

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IT IS A great honor and a privilege to have been invited to deliver the annual Charles Value Chapin Oration of the Rhode Island Medical Society. When George E. Vincent[1] addressed this Society in 1927 on the occasion of the testimonial exercises at the unveiling of Dr. Chapin's portrait he not only paid tribute to Dr. Chapin's devotion to the scientific method, to his outstanding contributions to the control of communicable disease and to his statesmanship in the broad field of public health, but also described in his felicitous way some of those qualities which made Dr. Chapin the great man that he was. Said Dr. Vincent, among many other things: "[Dr. Chapin] has such a terrible passion for presenting things just as they are;" and again "good team work . . . is one thing Dr. Chapin has made one of his hobbies . . ." And Dr. Place in his Charles V. Chapin Oration[2] two years ago appropriately singled out another characteristic of the man whom we honor this evening when he said, "Few men in the field of contagious diseases have been more alert to the changing views, or indeed have added more changes, than Dr. Chapin." A devotion to the scientific method, a passion for truth, a capacity for team work and an alertness to change, these are a group of qualities of which anyone might indeed be proud, but which Dr. Chapin in his characteristic modesty would have been the first to disclaim.

In selecting a subject for this address, then, it has naturally been my desire not only to choose one which would be appropriate for a talk which commemorates Dr. Chapin but also one which I hope may to some small extent be compatible with those qualities which so distinguished Dr. Chapin's career. In my title I have used the word "control" rather than "prevention" or "treatment" since it would appear to be a broad enough term to encompass both, for the prevention and treatment of infectious diseases are inextricably interwoven to form a symmetrical whole, which should be of equal interest to the practicing physician and the worker in the field of public health. Here again Dr. Chapin's pragmatic approach was unsurpassed. I quote, "Whatever the medical profession can do better than the State the medical profession should do. Whatever the State or a group of private citizens can do better than the doctors, the State and private organizations should do, whether it is preventive or curative."

Advances in the control of infectious diseases during recent years are writing a brilliant chapter in the history of medicine. Soundly based on scientific research, conspicuously the product of cooperative research, stimulated no doubt by the urgent necessities of war, they are bringing changes in prevention and treatment which open new vistas in the struggle of man against the parasites which beset him, if I may plagiarize a catch phrase, from the womb to the tomb. So numerous are they that it would be quite impossible to do more than catalogue them if all were to be touched upon in the time at

*The Fourth Annual Charles V. Chapin Oration presented at the 134th Annual Meeting of the Rhode Island Medical Society, at Providence, on May 16, 1945*
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my disposal. Force of circumstance, then, compels me to select a few by way of illustration of the whole.

In making these selections I have been guided by a desire to illustrate the several methods of approach commonly used in the attempt to control communicable disease, namely: the production of a temporary passive immunity by the injection of humoral antibodies; the stimulation of an active and more lasting immunity by vaccination; the prevention of threatened infection by the mass administration of a suppressive agent to the whole of an endangered population; sanitary environmental control, in this instance in an effort to reduce the incidence of acute respiratory diseases; and finally the prompt treatment and cure of communicable disease with antibiotics, a procedure which may serve not only to alleviate actual disease but also to prevent complications and sequelae as well as to reduce the chances of tranmission of the infection to others.

The advances which I propose to discuss have originated from the work of numerous investigators and, as I have said, are conspicuously the product of cooperative research. In large part they have been sponsored and supported by the Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army[3] or the Committee on Medical Research of the Office of Scientific Research and Development or both, through contracts with many of our Universities. The Army Epidemiological Board, as it is commonly called, was established on request of Surgeon General James C. Magee in January 1941 and has been in continuous operation since that time in the Preventive Medicine Service of The Surgeon General's Office in Washington under the stimulating guidance of Brig. Gen. James S. Simmons and the able administration of Brig. Gen. Stanhope Bayne-Jones. The central Board from the beginning has consisted of seven civilian consultants experienced in the field of infectious diseases: Dr. Francis G. Blake, President, Drs. Oswald T. Avery, Alphonse R. Dochez, Ernest W. Goodpasture, Kenneth F. Maxcy, O. H. Perry Pepper, and Andrew J. Warren. Operating under the Board are ten Commissions comprised of more than 100 civilian specialists in infectious diseases and 25 officers of the Army Medical Corps. These Commissions have been constantly engaged in both laboratory and field investigations in this country and overseas in an effort to advance knowledge about infectious diseases with the ultimate aim of improving methods of control. In a similar fashion and with the same aims in view, the Committee on Medical Research under the Chairmanship of Dr. A. N. Richards and with the advisory assistance of appropriate committees of the Division of Medical Sciences of the National Research Council has directed a part of its many activities toward the solution of problems of infection, particularly those of importance to our Armed Forces in the prosecution of the war. As in the case of the Army Epidemiological Board these have been cooperative undertakings in which numerous investigators have pooled their interests and collaborated effectively. When suitable opportunities arose the two organizations have joined in an effort to expedite the problems under investigation.

So much by way of introduction. Let us turn now to a consideration of some of the advances that have been made.

## CONTROL BY PASSIVE IMMUNIZATION

### MEASLES AND INFECTIOUS HEPATITIS

Two advances in the prevention of infectious diseases by the establishment of a temporary passive immunity in exposed susceptible individuals will be cited. The first, in the case of measles, represents an improvement in method, the second in the case of infectious hepatitis, a new and original observation.

Appropriately enough for this occasion you will recall that one of your own distinguished physicians here in Providence, Dr. D. L. Richardson[4] successfully initiated passive immunization against measles with convalescent measles serum and presented a paper on this subject before this society on March 7, 1919. In that paper Dr. Richardson stated, "The attempt at immunization against this disease was suggested by Dr. Charles V. Chapin," and he concluded with commendable caution that, "The experiments are too few to be conclusive, but they are sufficiently suggestive to warrant further investigation."

Subsequent experience during the ensuing quarter of a century has served fully to confirm Dr. Richardson's original observation as shown by the data compiled from the literature by McKhann.[5] Of 1627 cases receiving convalescent serum, unselected with respect to dosage or time after exposure when serum was injected, 75 per cent were fully protected, 17 per cent were partially protected, the measles which occurred being attenuated, while only 8 per cent came down with unmodified measles. Similar, though somewhat less satisfactory results have been obtained with pooled adult serum and

globulin derived from human placentas.

With the background of these observations as a starting point it seemed probable that the concentrated preparations of serum globulins, which had become available through the work of Cohn, Oncley, Strong, Hughes and Armstrong[6] on the fractionation of pooled human plasma and which had been shown by Enders[7] to contain a variety of antibodies in concentrated form, particularly in fraction II containing the gamma globulins, should be useful for preventing or attenuating measles. Consequently Stokes, Maris and Gellis of the Commission on Measles and Mumps of the Army Epidemiological Board and Ordman, Jennings and Janeway for the Committee on Medical Research undertook studies to determine whether this supposition might be true and have recently reported the results of their observations.[8,9] It was found by both that concentrated normal human serum gamma globulin was highly effective in preventing or attenuating measles, that no significant untoward reactions were observed in any of the inoculated cases, that a dosage of 2.5 cc. in smaller children and 5.0 cc. in older children was adequate for protection in most instances, if the injection was given within the first five days after exposure, but that from the sixth day onward the percentage of attenuated cases and failures increased. To cite but one example from these studies Ordman, Jennings and Janeway[9] report that in a controlled group of cases with intimate family exposure protection was afforded in 71 per cent and attenuation in 27 per cent with only a 2 per cent failure among 62 inoculated children, while among 46 uninoculated controls 89 per cent developed measles of average severity, 4 per cent had mild measles and only 7 per cent failed to contract the disease. The use of normal human gamma globulin for the prevention or attenuation of measles would appear to be a distinct advance since it offers the definite advantages of being readily produced from an abundant source of supply, it is effective in small doses, and its administration is devoid of significant local or general reactions.

Epidemic catarrhal jaundice or infectious hepatitis, as it is now commonly called, has long been recognized as a clinical entity occurring in epidemic outbreaks in this country and abroad, particularly in schools or similar institutional groups. Until quite recently, however, its etiology and method of transmission have been quite unknown, and no method of prevention or specific treatment has been available. With this war, as in previous wars, epidemics of infectious hepatitis have become a problem of military importance.[10,11] As a result a great deal of work has been directed toward the discovery of the etiological agent and the elucidation of the mode of transmission. Through the studies of MacCallum and Bradley,[12] Havens, Ward, Drill and Paul,[13] and of others, which it is not our purpose to review here, it has been shown that the disease can be readily transmitted to human volunteers by an agent present in the blood serum and feces of patients with the disease, either by injection or by feeding of the infective material. As in homologous serum jaundice and post-vaccinal jaundice (Oliphant[14]) the agent of infectious hepatitis is filtrable, withstands heating to 56°C. for 30 minutes and can be transmitted in serial passage in human volunteers (Havens[15]). While these two icterogenic agents or viruses possess some characteristics in common the relationship between them is not yet clear.

Of particular interest for the present discussion is the original observation of Stokes and Neefe[16] of the Commission on Measles and Mumps of the Army Epidemiological Board that concentrated gamma globulin[6] may be effective in the control of epidemics of infectious hepatitis. In a well controlled study of the protective value of gamma globulin in an extensive epidemic of infectious hepatitis which occurred in a summer camp during August and September 1944, the overall incidence of hepatitis was 20.8 per cent in 53 subjects injected intramuscularly with globulin in an arbitrary dosage of 0.15 cc. per pound of body weight, 67.0 per cent in 278 uninjected controls. Further analysis showed that only 3 of the 11 injected subjects who contracted hepatitis or 27.3 per cent developed jaundice, which was only a mild scleral icterus of four to seven days duration, while 125 or 67.6 per cent of the 185 controls who developed hepatitis became jaundiced. Furthermore the onset of hepatitis in the 11 persons who received gamma globulin occurred during the first ten days after the injection, while cases continued to appear among the controls for thirty-two days, a result which suggested that the administration of gamma globulin late in the incubation period brought about attenuation rather than prevention of the disease. The outcome of this experiment is statistically significant and in the words of the authors warrants further trial of gamma globulin as a means of controlling epidemics of infectious hepatitis. In fact confirmation is already at hand through a recent similar study of an epidemic of hepatitis in an orphanage by Paul[17] and

Havens of the Commission on Neurotropic Virus Diseases of the Army Epidemiological Board, the results of which have not yet been published.

The use of gamma globulin for the prevention or attenuation of epidemic infectious hepatitis would appear to be a real advance in the control of a hitherto uncontrollable disease sufficiently promising to warrant further trial when opportunity arises in order that its usefulness may be exactly defined under varying circumstances.

### CONTROL BY ACTIVE IMMUNIZATION

### INFLUENZA

Active immunization against infectious diseases by inoculation with an appropriate antigen, whether a vaccine or a toxoid, is a well established procedure which has proved more or less effective in a variety of diseases such as smallpox, diphtheria, typhoid fever, tetanus, yellow fever, rabies, and epidemic louse-borne typhus.

Although many efforts had been made prior to 1941 to develop an effective vaccine against epidemic influenza, no definite answer to the essential question of whether effective prophylaxis against influenza was obtainable was at hand at that time. Consequently, one of the first tasks which the Army Epidemiological Board undertook through its Commission on Influenza under the direction of Dr. Thomas Francis, Jr., was a solution of this problem. The results which have been obtained to date would appear to have provided a sufficiently definite answer to have placed the control of influenza, at least epidemic influenza A and perhaps influenza B, well within the realm of possibility if not of probability.

In 1942 Francis and Salk[18] devised a simplified method for the preparation of a concentrated and purified influenza virus vaccine based upon the observations of Hirst[19] that influenza virus grown in the chorioallantoic fluid of the chick embryo can be adsorbed by the erythrocytes of the embryo and then readily eluted from the red blood cells. Each 1.0 cc. of the finished vaccine which was inactivated with formaldehyde, contained the amount of Type A virus (PR 8 and Weiss strains in equal parts) recovered from 5.0 cc. of allantoic fluid, and the amount of Type B virus (Lee strain) recovered from an equivalent amount of allantoic fluid. This vaccine was then demonstrated to be capable not only of stimulating the production of antibodies and actively immunizing mice, but also of furnishing definite protection in human beings against experimental induction of influenza A[20] and influenza B.[21]

Based on the foregoing results and with the expectation that there might be an epidemic of influenza during the 1943-44 respiratory disease season, a plan was drawn up and preparations made through Preventive Medicine Service, Office of the Surgeon General for the Commission on Influenza to test the efficacy of the vaccine in a well controlled study in Army Specialized Training Program units in eight universities in different parts of the country and in five New York medical and dental schools. The nine groups comprised 12,474 men of which 6,263 were injected subcutaneously with a single dose of 1.0 cc. of the vaccine, while 6,211 alternate controls received an inert injection of similar volume. The vaccination was carried out during the fall of 1943 and was in the main completed by the middle of November. Fortunately for the experiment an epidemic of influenza began during the latter half of November, reached its peak in the first half of December, and then promptly subsided. This outbreak of influenza was promptly detected in Michigan[22] and Minnesota,[23] quickly shown to be due to Type A influenza virus, and all units were immediately notified. Careful clinical observations were made throughout the epidemic and all diagnoses recorded without knowledge of whether the individual diagnosed as having influenza was in the vaccinated or control group. The individual group and overall results have been published in a preliminary report[24] and may be summarized briefly as follows: vaccination with a single subcutaneous injection of 1.0 cc. of a concentrated inactivated influenza vaccine done shortly before or even after the onset of the influenza Type A epidemic of 1943 exerted a marked though not complete protective effect with a total attack rate of 2.22 per cent among the 6,263 vaccinated persons as compared with an attack rate of 7.11 per cent in a rigidly comparable group of 6,211 controls. In other words 76.2 per cent of the cases of influenza occurred among the controls, only 23.8 per cent among the vaccinated. In one group in which vaccination was not done until the epidemic had been under way for 12 days, the protective effect of the vaccination became apparent about one week following the vaccination at which time there was a sharp drop in incidence in the vaccinated group as compared with a continued precipitous rise among the controls.

While the data from this study do not furnish final conclusions concerning all problems, such as the duration of immunity following vaccination nor the best ultimate method of vaccinating and best

type of vaccine, they have shown clearly for the first time that vaccination shortly before an epidemic exerts a pronounced effect upon susceptibility to influenza A during an epidemic of high incidence.

These additional problems are now under investigation in an effort to determine whether a more effective concentrated and purified vaccine can be prepared by ultracentrifugation according to the methods described by Beard[25] and by Stanley,[26] whether a modification of the dosage schedule may increase or prolong the period of immunity, and what the duration of immunity may be. Whether the advance which has already been made in the control of epidemic influenza A will be equally effective in influenza B or effective at all in severe pandemic influenza remains to be determined.

### PREVENTION OF THREATENED INFECTION BY MASS ADMINISTRATION OF A SUPPRESSIVE AGENT MENINGOCOCCAL MENINGITIS

In the Charles V. Chapin Oration of two years ago Dr. Place[2] stated: "With our present data, it is obvious that any attempt to control sources of [Meningococcus] infection would have to go beyond the patients with recognizable symptoms or even their known immediate contacts and include a large proportion of population. . . . It is not improbable with the growing knowledge of efficient means of carrier cure that the present [tendency to ignore the carriers] may again be reversed." This prophetic suggestion was already being submitted to experimental investigation by Mueller,[27] and Phair and Schoenbach[28,29] of the Commissions on Epidemiological Survey and Meningococcal Meningitis, respectively, of the Army Epidemiological Board, and by Kuhns, Nelson, Feldman and Kuhn[30] in a controlled field trial at an Army post during the epidemic of meningococcal meningitis during the first half of 1943.

For these studies sulfadiazine was selected because of its known effectiveness in the treatment of meningococcal meningitis as the most suitable mass prophlyactic agent for trial in an effort to determine whether meningococci could be promptly eliminated from the nasopharynx of carriers as a means of checking the spread of meningitis during epidemic outbreaks of the disease. All three groups of investigators were able to show that sulfadiazine was highly effective in promptly curing the carrier state. Phair and Schoenbach[29] in a series of carefully controlled studies demonstrated that a single dose of 2.0 grams of sulfadiazine given orally was the minimal effective dose and was equally active for Group I, Group II, and Type IIa meningococci. Parasitic cure was obtained in 95 to 100 per cent of the carriers or "subclinical infections," as Phair prefers to call them, within 24 to 48 hours. Kuhns[30] and his collaborators used 3.0 grams daily for 3 days in one experiment and 2.0 grams daily for 2 days in another and found the smaller dosage as effective as the larger in eliminating carriers and stopping the epidemic in the treated group. Mueller,[27] on the other hand, feels that the larger dosage and more prolonged treatment is desirable if the best results are to be obtained.

It may be concluded from these studies that in relatively isolated groups of individuals the mass prophylactic administration of sulfadiazine to all members of the group is a feasible and effective method for rapidly decreasing the prevalence of meningococcal infections in the group but that further experience is necessary to determine the most suitable dosage for terminating an epidemic. A word of caution is necessary, however, particularly with respect to epidemic meningitis in the general population, for, as pointed out by Phair,[31] a single mass prophylactic administration of sulfadiazine obviously cannot control the incidence of reacquisition of subclinical infections indefinitely. By this procedure only immediate parasitic suppression is attained and there is no ground for the assumption that the sulfonamides confer freedom from, or enhance resistance to subsequent infection over any long period of time if members of the treated group mingle with an untreated group with a higher carrier rate. The rapidity with which the treated groups will attain the prevalence level of the general community in the post sulfonamide period will depend upon the degree of re-exposure. Although mass prophylaxis with sulfadiazine is a distinct advance in the control of epidemic meningitis, its utilization for the suppression of country-wide epidemics in the civilian population is beset with practical difficulties and has obvious limitations. Nevertheless it might seem wise in the case of a community outbreak to give mass sulfadiazine prophylaxis to all members of the community every three weeks until the epidemic period has passed.

Another example of research on the prevention or suppression of threatened infection by mass administration of a suppressive agent, such as the attempted control of hemolytic streptococcal infections by the daily administration of small doses of sulfadiazine during the respiratory disease season,[32]

may be cited but cannot be discussed in detail for want of time. In brief it may be said of sulfadiazine prophylaxis of hemolytic streptococcal respiratory infections that, although considerable evidence in support of its effectiveness has been accumulated,[32] recent experience with the appearance of sulfonamide resistant strains of streptococci, possibly as an evolutionary selective development of the widespread use of sulfonamides, has introduced a note of warning with respect to the general application of this procedure. Limited trial in serious institutional epidemics, on the other hand, may be justified, at least until the possible benefits and possible dangers have been more thoroughly assessed.

A further well known example is the successful suppression of the clinical manifestations of malaria by the continuous administration of atabrine to those exposed to the bites of infected mosquitoes. Although many important advances have been made in defining the proper application of this procedure and in reducing non effectiveness from malaria, atabrine does not prevent infection with *Plasmodium vivax* and the search for a true preventive continues.[33] Information concerning this work, which is being carried on under the auspices of the Committee on Medical Research of the Office of Scientific Research and Development is restricted in the interests of national safety and cannot be discussed at this time.

### SANITARY ENVIRONMENTAL CONTROL OF ACUTE RESPIRATORY DISEASES

The success which has been achieved by sanitary science in the control of water-, milk-, food- and insect-borne diseases has no parallel up to the present in the sanitary control of acute respiratory disease. In fact and irrespective of whether the acute respiratory diseases are contact, air-borne, droplet or dust-borne infections, their general control by sanitary measures has seemed until quite recently to be an almost insurmountable problem, so long as man lives in intimate daily contact with his fellows and must breathe to live. Yet despite the apparent hopelessness of the problem, much has been accomplished in the control of hospital cross infection, as recently set forth in an excellent historical review of the subject by Cruickshank,[34] and a beginning has been made which may perhaps lead eventually to some measure of control of wider application.

I shall discuss briefly here only two procedures, one initiated by Robertson, Bigg, Miller and Baker[35] and both later carried forward by Robertson and his collaborators, Puck, Loosli, Lemon, Wise and Hamburger[41] of the Commission on Air-Borne Infections of the Army Epidemiological Board with additional support from the Committee on Medical Research, namely,—the sterilization of air with glycol vapors and the oiling of floors and bed clothes.

Robertson[36] summarized the basic work on sterilization of air with glycol vapors in his Harvey Lecture of April 1943. In brief propylene glycol in a concentration of one gram in 5 million to 10 million cc. of air, and triethylene glycol in a concentration of one gram to several hundred million cc. of air were found to be lethal within seconds to minutes, depending on the concentration and the kind of glycol, for the common respiratory pathogens including pneumococci, hemolytic streptococci, H. influenzae, H. pertussis and the virus of influenza. The vapor affected the air-suspended organisms through abundant collisions between the hygroscopic glycol molecules and the bacteria- or virus-containing droplets. Desiccated bacterial particles on the other hand were not as susceptible to the vapor action as moist ones and the glycols were most effective at relative humidities between 40 and 60 per cent. No deleterious effects were found in rats and monkeys from prolonged inhalation of glycol vapor for periods up to eighteen months.

The engineering problems involved in the practical application of these findings have been under investigation during the past two years and would appear to be nearing solution[37] so that practical tests of the value of glycol vapor in reducing the incidence of respiratory infections, which are extremely meagre at present, may be instituted.

Numerous studies during recent years have shown that not only the air but also floor dust and bedding may be heavily contaminated with hemolytic streptococci in indoor environments where carriers of hemolytic streptococci or those sick with streptococcal infections are housed.[34,38] The control of these latter sources for the dissemination of bacteria as a supplement to the use of aerosols would appear to be an important aspect of the attempt to control air-borne infection. In 1940, Van den Ende, Lush, and Edward[39] showed that the control of contaminated floor dust may be easily accomplished in barracks by means of oiling, but that on smooth floors of hospital wards it was necessary to use mopping or a special floor compound. The problem of treatment of bedding to prevent liberation of bacteria, first investigated by Thomas and Van den Ende,[40] has recently been solved by the Com-

mission on Air-Borne Infections[41] through the development of a practical and inexpensive oiling procedure for blankets and bed linen. Preliminary studies have shown that by a combination of floor oiling and the oiling of bed clothing the large numbers of hemolytic streptococci recoverable from the bedding and the air of heavily contaminated barracks can be markedly reduced and that by a combination of the oiling procedures with triethylene glycol vapor a reduction of 90 per cent or more may be promptly attained in hospital wards.

What the actual effectiveness of these sanitary methods may be in controlling respiratory infections remains to be determined by much further study under properly controlled experimental conditions. While it seems not at all improbable that they may prove to be of considerable value among hospital and other institutional populations, their more general utility would appear *a priori* to be limited by the fact that much transmission of respiratory infection presumably occurs under situations in which they could not be used.

## TREATMENT OF COMMUNICABLE DISEASE WITH ANTIBIOTICS

### SYPHILIS

The remarkable advance which has occurred in the control of numerous infectious diseases through the introduction of sulfonamides and more recently of penicillin is too broad and familiar a subject to warrant a general discussion. It would seem neglectful, however, if a few words were not said about the treatment of early syphilis with penicillin, for this may well prove to be one of the more important advances of the day. Two years ago Mahoney, Arnold and Harris[42] of the Venereal Disease Research Laboratory and the United States Marine Hospital on Staten Island, N. Y., undertook an exploration of the influence of penicillin therapy on the clinical manifestations and serologic reactions of four patients with primary syphilis, all of whom displayed darkfield positive lesions. All four experienced a rapid healing of the primary lesions, which became promptly darkfield negative, and all attained sero-negativity within three months. As a result of these observations a cooperative study of the effect of penicillin in syphilis in human beings was organized in September 1943 under the general auspices of the Committee on Medical Research and the specific direction of a Penicillin Panel appointed by the Subcommittee on Venereal Disease, National Research Council. Participating in the study are a large group of Army, Navy, U. S. Public Health Service and civilian hospital clinics. While the final results of this study obviously cannot be available for some time to come, a preliminary analysis by Moore, Mahoney, Schwartz, Sternberg and Wood[43] of the results obtained in 1,418 cases of early primary and secondary syphilis treated with several different dosage schedules appears to have established the following points: (1) penicillin has a profound immediate effect especially in primary but also in early secondary syphilis with respect to rapid disappearance within less than 24 hours of surface Treponema pallidum from open lesions and the rapid healing of lesions; (2) serological reversal ensues within the following 3 to 6 months in the majority of cases; (3) the incidence of subsequent serological or clinical relapse bears a direct relationship to the total dosage given; (4) the optimum time-dose relationship of penicillin in early syphilis and the possible advantage of combined therapy with mapharsen is not yet established but it would already appear that the minimum dose, especially in secondary syphilis, should not be less than 20,000 units intramuscularly every 3 hours for 7½ to 10 days, or a total of 1,200,000 to 1,600,000 units. (5) Herxheimer reactions are frequent but not serious and other reactions are negligible.

Our own experience in the treatment of 80 cases at the New Haven Hospital would lead us to agree with these tentative conclusions, but we would like to suggest on the basis of the first 12 cases treated with 10,000 units every 2 hours for 8 days, before we joined the cooperative study which required a 3 hour interval, that the maintenance of a constantly higher blood level of penicillin than can be attained by a 3 hour interval schedule may be advantageous.

Whatever the ultimate place of penicillin may be in the treatment of syphilis, the mere fact that practically all cases of early syphilis receiving therapy can be promptly rendered non infectious and will receive a full course of treatment in a brief time without the risks associated with massive arsenotherapy may be accepted as a significant advance in the control of venereal disease.

In the course of this discourse a number of illustrative examples of recent progress in the control of infectious diseases have been cited. There are many others already made or in the making, such as the new repellants and insecticides for the control of insect-borne diseases,[44] too numerous to be touched upon here. Suffice it to say by way of conclusion that our knowledge about many of them,

as well as the subjects which have been discussed, is still fragmentary but this need not disturb us so long as progress continues to be made. Much that may seem sound and promising today will doubtless be modified or even discarded tomorrow through further experiment, but of this, as Dr. Chapin once said, "We should not be ashamed . . ." nor need we be, so long as we "keep an open but not an empty mind;"[2] so long as we remain alert to the advances which scientific research provides but are not too hasty and uncritical in the application of new discoveries, until their validity be well established.

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# A TEN-YEAR REPORT OF THE TUMOR REGISTRY OF THE YALE UNIVERSITY SCHOOL OF MEDICINE

## Based on Total Admissions for Cancer to the New Haven Hospital 1935-1944

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IN JULY, 1940,* a grant was made to the Yale University School of Medicine, Department of Surgery, by the Jane Coffin Childs Memorial Fund for Medical Research, for the establishment of a tumor registry. The work has been supported since then by annual grants from this fund. The first objective was to plan and establish a complete registry of all cases admitted to or discharged from this institution with a diagnosis of cancer. Some of the groundwork had been done, for studies had been made on selected records of certain sites, notably rectum, stomach, colon, lip and breast, and the abstracted tumor records for these were a nucleus for the registry. These records went back to 1921 for some sites. Most of them were from 1937, and in no instance were they complete for any year. The basis for their selection had been usually the surgical pathological reports. The second objective was to ascertain the status of all previous admissions by the initiation of follow-up on all untraced cases and the active continuation of follow-up on the current and traced cases. The third objective was to encourage the use of the registry and to assist as statistical research advisor those students or physicians seeking such help. By September the physical equipment of office space, files and machines had been obtained.

Work was begun on the current cases. As rapidly as possible abstracting of previous admissions together with follow-up was carried on until it was complete from January, 1935. Follow-up has been established on 93.9 per cent of all cases. Some idea of the volume of this phase of the work may be realized from the knowledge that for the 1,279 cases living, 9,505 separate follow-up contacts were made or an average of nearly seven and one half per person. For the 172 living breast cases alone there were 1,384 follow-ups, and for the 33 stomach cases there were 238 follow-ups. The number of follow-up contacts for the dead ran slightly higher even though many of them had died before active follow-up of all cases was attempted, and the death information had been obtained from the State Bureau of Vital Statistics. Studies have been made continually. The last year has witnessed a marked increase in this activity. As the registry approached completion and current cases were added as soon as they became known to

*The date is correct so far as the official Registry is concerned. In July, 1938, a grant was made to the Tumor Clinic by the Coffin Childs Fund, part of which was used to buy files and equipment still in use in the Registry. More important was the effect it had of stimulating the interest which made this Registry possible.

*From the Tumor Registry of the Department of Surgery, Yale University School of Medicine. This study was aided by grants from the Coffin Childs Memorial Fund for Medical Research*

the hospital, the demands on the research aspects of the work have mounted as was expected.

This report is based on the 3,561 tumor records which have been abstracted or revised since 1940. Some of the 1944 records are not included because additional information is being awaited and fifteen of the earlier records of 1945 are included. The accompanying tables give in detail a broad picture of the magnitude of the problem of cancer in a general hospital of this size. Approximately 3.7 per cent of the total admissions to this hospital annually are for cancer. When it is realized that cancer is gradually increasing with the aging of the population, the opinion is confirmed of the consensus of hospital administrators in a recently conducted unpublished survey by the Division of Cancer Research of the Connecticut State Department of Health, that there will be a transference of some of the existing facilities to cancer as chronic disease replaces some of the present emergencies, and the expansion of facilities is going to take into consideration the peculiar requirements of chronic illness, particularly in its sometimes frequent acute phases.[1]

Of the total admissions for cancer over the ten-year period, 40 per cent were residents of New Haven, 2.5 per cent came from outside the state, and the rest are from nearly every community in Connecticut including all the larger cities with general hospitals of their own. Whether affiliation with a medical school is responsible for the large non resident incidence in this hospital is problematical. Among males 87.8 per cent and among females 83.6 per cent were primary admissions to the New Haven Hospital.

The total individuals known to the registry by year of admission by sex is shown in Table I. That males comprise 55.6 per cent of the total is worthy of notice since this is not regularly the case in cancer.

Table II gives the present status of the cancer population by year of admission by sex. This marks a 65 per cent increase in attendance from 1935 to 1943. The records for 1944 are still coming in. Deferred and questionable diagnoses cause delay in record abstraction. The five-year survivals represent 22.2 per cent of the total admissions for males from 1935 through 1939 and 19.8 per cent of females. The records of those listed as dead have been verified in the local bureau of vital statistics. The death records of those listed as untraced, most of whom were residents of the state, have been sought in the State Bureau of Vital Statistics without success.

Table I

Total Individuals With Cancer by Year of Admission by Sex

1935-1945*

| YEAR | MALES | FEMALES | TOTAL |
|---|---|---|---|
| 1935 | 141 | 116 | 257 |
| 1936 | 133 | 116 | 249 |
| 1937 | 147 | 147 | 294 |
| 1938 | 182 | 159 | 341 |
| 1939 | 187 | 158 | 345 |
| 1940 | 210 | 164 | 374 |
| 1941 | 253 | 179 | 432 |
| 1942 | 250 | 204 | 454 |
| 1943 | 244 | 181 | 425 |
| 1944 | 225 | 150 | 375 |
| 1945 | 7 | 8 | 15 |
| Total | 1979 | 1582 | 3561 |
| Per cent | 55.6 | 44.4 | 100.0 |

*1944 and 1945 still coming in

Table II

Present Status of Cancer Population by Year of Admission

1935-1945*

| YEAR | LIVING | PER CENT | DEAD | UNTRACED | TOTAL |
|---|---|---|---|---|---|
| **MALES** | | | | | |
| 1935 | 22 | 15.6 | 114 | 5 | 141 |
| 1936 | 20 | 15.0 | 108 | 5 | 133 |
| 1937 | 36 | 24.5 | 105 | 6 | 147 |
| 1938 | 41 | 22.5 | 124 | 17 | 182 |
| 1939 | 56 | 29.9 | 115 | 16 | 187 |
| 1940 | 51 | 24.3 | 135 | 24 | 210 |
| 1941 | 88 | 34.8 | 136 | 29 | 253 |
| 1942 | 104 | 41.6 | 146 | .... | 250 |
| 1943 | 121 | 49.6 | 123 | .... | 244 |
| 1944 | 153 | 68.0 | 72 | .... | 225 |
| 1945 | 6 | | 1 | .... | 7 |
| Total | 698 | 35.3 | 1179 | 102 | 1979 |
| **FEMALES** | | | | | |
| 1935 | 13 | 11.2 | 97 | 6 | 116 |
| 1936 | 22 | 19.0 | 85 | 9 | 116 |
| 1937 | 33 | 22.4 | 101 | 13 | 147 |
| 1938 | 29 | 18.2 | 120 | 10 | 159 |
| 1939 | 41 | 25.9 | 98 | 19 | 158 |
| 1940 | 39 | 23.8 | 86 | 39 | 164 |
| 1941 | 78 | 43.6 | 80 | 21 | 179 |
| 1942 | 92 | 45.1 | 112 | .... | 204 |
| 1943 | 110 | 60.8 | 71 | .... | 181 |
| 1944 | 117 | 78.0 | 33 | .... | 150 |
| 1945 | 7 | | 1 | .... | 8 |
| Total | 581 | 36.7 | 884 | 117 | 1582 |

*1944 and 1945 still coming in

Table III lists presence or absence of pathological proof of cancer by year of admission by sex. Among females pathological proof was present in 88.8 per cent of the total cases and among males in 86.5 per cent.

Table III

Distribution of Hospitalized Cancer Cases by Microscopic Proof by Year

| | MALES | | | | FEMALES | | | |
|---|---|---|---|---|---|---|---|---|
| YEAR | YES | PER CENT | NO | TOTAL | YES | PER CENT | NO | TOTAL |
| 1935 | 114 | 80.9 | 27 | 141 | 94 | 81.0 | 22 | 116 |
| 1936 | 111 | 83.5 | 22 | 133 | 100 | 86.2 | 16 | 116 |
| 1937 | 131 | 89.1 | 16 | 147 | 124 | 84.4 | 23 | 147 |
| 1938 | 148 | 81.3 | 34 | 182 | 146 | 91.8 | 13 | 159 |
| 1939 | 165 | 88.2 | 22 | 187 | 144 | 91.1 | 14 | 158 |
| 1940 | 190 | 90.5 | 20 | 210 | 155 | 94.5 | 9 | 164 |
| 1941 | 236 | 93.3 | 17 | 253 | 168 | 93.9 | 11 | 179 |
| 1942 | 215 | 86.0 | 35 | 250 | 177 | 86.8 | 27 | 204 |
| 1943 | 193 | 79.1 | 51 | 244 | 154 | 85.1 | 27 | 181 |
| 1944 | 201 | 89.3 | 24 | 225 | 135 | 90.0 | 15 | 150 |
| 1945 | 7 | | .... | 7 | 8 | | .... | 8 |
| Total | 1711 | 86.5 | 268 | 1979 | 1405 | 88.8 | 177 | 1582 |

*1944 and 1945 still coming in

A study of patient status in the hospital showed that 69.6 per cent of the male admissions for cancer and 61.0 per cent of the female admissions were ward. The color distribution was approximately the same as for the total population of the state, 98.0 per cent white among males and 96.4 per cent white among females. Marital status showed practically no difference between males and females, approximately 80 per cent of each being either married or widowed and 13 per cent of each being single.

Table IV was prepared on family history for cancer among cancer patients. This is inconclusive because of the large number of individuals who did not state or were not asked this question (25.7 per cent males, 28.9 per cent females) and those who were asked and did not know (4.6 per cent males, 3.5 per cent females). The similarities and dissimilarities in the information by sex is of interest. Of males 57.7 per cent claimed no family history for cancer. Of females 50.6 per cent had no family history of this disease. Among males 12.0 per cent of the total gave a family history of cancer; 11.6 per cent of these were in the parents, brothers and sisters; 5.4 per cent of this familial cancer occurred in sisters and mother; and 6.2 per cent in father and brothers.

Table IV

Family History for Cancer

| | MALES | PER CENT | FEMALES | PER CENT | TOTAL | PER CENT |
|---|---|---|---|---|---|---|
| None | 1142 | 57.71 | 801 | 50.63 | 1943 | 54.56 |
| Father | 75 | 3.79 | 49 | 3.10 | 124 | 3.48 |
| Mother | 57 | 2.88 | 104 | 6.57 | 161 | 4.52 |
| One brother | 39 | 1.97 | 31 | 1.96 | 70 | 1.97 |
| More than one brother | 9 | .45 | 6 | .38 | 15 | .42 |
| One sister | 48 | 2.43 | 41 | 2.59 | 89 | 2.50 |
| More than one sister | 2 | .10 | 5 | .32 | 7 | .20 |
| Aunts or uncles | 18 | .91 | 26 | 1.64 | 44 | 1.24 |
| Other relatives | 37 | 1.87 | 49 | 3.10 | 86 | 2.42 |
| Not stated | 509 | 25.72 | 457 | 28.89 | 966 | 27.13 |
| Positive unclassified | 2 | .10 | 2 | .13 | 4 | .11 |
| Unknown | 90 | 4.55 | 55 | 3.48 | 145 | 4.07 |
| Case Total† | 1979 | | 1582 | | 3561 | |

*1944 and 1945 still coming in

†Case totals less than summed totals. Some individuals had more than one relative with cancer

Among females there was a positive family history for cancer in 17.0 per cent of the total cases. Of this number 14.9 per cent occurred in the immediate family; 5.4 per cent in the father and brothers, and 9.5 per cent in the mother and sisters.

The distribution of the population of patients by year of admission to hospital by age and sex is shown in the next table. Average age and percentage distribution of the whole period by age have been computed and listed. Generally the average age at time of admission is increasing. It is evident that cancer occurs at every age.

In Table VI the stage of disease on admission to hospital is given by age, sex, and year. When first seen in this hospital 47.3 per cent of the total admissions for males had localized involvement, 21.5 regional involvement, and 15.6 per cent remote metastases. Among females, when first seen in this hospital, 45.3 per cent had localized involvement, 23.0 per cent had regional involvement, and 16.1 per cent had remote metastases. Interesting and significant findings are inherent in this table. There has been a significant improvement in the increase of individuals in whom cancer was localized at time of admission in the second five-year period over the first five-year period among females. There has been a significant decrease in the presence of remote metastases upon admission in the last five-year period

Table V

Distribution of Population of Patients With Cancer by Year of Admission to Hospital by Age and Sex

1935-1945*

Males

| AGE GROUPS | 1935 | 1936 | 1937 | 1938 | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 | 1945 | TOTALS | PERCENTAGE DISTRIBUTION |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-9 | 4 | 1 | 2 | 4 | 2 | 0 | 2 | 3 | 3 | 1 | 0 | 22 | 1.1 |
| 10-19 | 2 | 2 | 3 | 1 | 0 | 2 | 3 | 4 | 5 | 0 | 0 | 22 | 1.1 |
| 20-29 | 4 | 3 | 5 | 3 | 8 | 8 | 8 | 8 | 8 | 2 | 0 | 57 | 2.9 |
| 30-39 | 3 | 3 | 7 | 4 | 11 | 9 | 14 | 8 | 11 | 8 | 0 | 78 | 3.9 |
| 40-49 | 23 | 15 | 17 | 17 | 30 | 16 | 32 | 30 | 19 | 17 | 0 | 216 | 10.9 |
| 50-59 | 34 | 34 | 38 | 57 | 53 | 58 | 63 | 55 | 54 | 65 | 2 | 513 | 25.9 |
| 60-69 | 42 | 43 | 41 | 51 | 43 | 58 | 70 | 78 | 69 | 76 | 2 | 573 | 29.0 |
| 70-79 | 23 | 23 | 27 | 40 | 26 | 49 | 45 | 42 | 66 | 44 | 2 | 387 | 19.6 |
| 80-89 | 6 | 7 | 7 | 4 | 11 | 8 | 15 | 21 | 9 | 12 | 1 | 101 | 5.1 |
| 90+ | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 2 | .1 |
| Unknown | 0 | 2 | 0 | 1 | 3 | 1 | 1 | 0 | 0 | 0 | 0 | 8 | .4 |
| Total | 141 | 133 | 147 | 182 | 187 | 210 | 253 | 250 | 244 | 225 | 7 | 1979 | 100.0 |
| Ave. age | 57.6 | 60.1 | 58.3 | 59.7 | 57.3 | 60.6 | 58.9 | 60.1 | 60.2 | 61.9 | | | |

Females

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-9 | 3 | 0 | 0 | 2 | 1 | 0 | 3 | 4 | 2 | 2 | 0 | 17 | 1.1 |
| 10-19 | 4 | 0 | 4 | 4 | 4 | 4 | 1 | 2 | 1 | 1 | 0 | 25 | 1.6 |
| 20-29 | 4 | 2 | 6 | 1 | 1 | 9 | 5 | 4 | 2 | 6 | 0 | 40 | 2.5 |
| 30-39 | 13 | 8 | 16 | 16 | 15 | 14 | 17 | 17 | 16 | 17 | 1 | 150 | 9.5 |
| 40-49 | 22 | 24 | 28 | 27 | 27 | 30 | 20 | 43 | 36 | 31 | 1 | 289 | 18.3 |
| 50-59 | 23 | 34 | 32 | 35 | 39 | 31 | 50 | 54 | 52 | 28 | 4 | 382 | 24.1 |
| 60-69 | 31 | 26 | 35 | 39 | 41 | 39 | 47 | 49 | 32 | 32 | 1 | 372 | 23.5 |
| 70-79 | 13 | 17 | 20 | 25 | 25 | 24 | 28 | 21 | 32 | 29 | 1 | 235 | 14.8 |
| 80-89 | 3 | 2 | 6 | 5 | 4 | 2 | 4 | 8 | 8 | 4 | 0 | 46 | 2.9 |
| 90+ | 0 | 1 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 4 | .3 |
| Unknown | 0 | 2 | 0 | 5 | 1 | 9 | 3 | 2 | 0 | 0 | 0 | 22 | 1.4 |
| Total | 116 | 116 | 147 | 159 | 158 | 164 | 179 | 204 | 181 | 150 | 8 | 1582 | 100.0 |
| Ave. age | 52.8 | 57.1 | 54.9 | 56.0 | 56.4 | 55.0 | 56.8 | 54.9 | 56.8 | 55.3 | | | |

*1944 and 1945 still coming in

over the first period among males. Among females there has been a decrease in those in whom remote metastases was present on admission, but it is not significant statistically.

What factors have caused this improvement in early detection of cancer? Has it been education of the public or earlier detection on the part of the practitioner? Or is it the natural course of events following the general, increased interest which began so earnestly in this state with the appointment of the Tumor Study Committee in the Connecticut State Medical Society in 1933? The members of the staff of the New Haven Hospital have been active participants in this cancer work from the beginning.

The series of breast cases is large with a relatively high survival rate. Additional sorts were made on these records at the request of a cancer research worker interested in the educational potential in these data to determine the present status of these cases according to the stage of disease when the patient first reported for treatment.[2]

Of the 169 living females who have been treated for breast cancer, 87 or 51.5 per cent reported for treatment with cancer localized, 31.4 per cent with regional involvement, 10.0 per cent with remote metastases, and 7.1 per cent in the other categories.

## Table VI

### Stage of Disease on Admission of Individuals With Cancer by Year and Sex

1935-1945*

#### Males

| Year | Localized | Regional involvement | Remote metastases | Recurrent after operation | Recurrent after radiation | Recurrent after operation and radiation | Post operative cancer, no evidence of recurrence | Unknown | Not stated | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| 1935 | 77 | 22 | 19 | .... | 1 | 4 | .... | 17 | 1 | 141 |
| 1936 | 62 | 22 | 27 | 3 | .... | 2 | .... | 16 | 1 | 133 |
| 1937 | 73 | 30 | 31 | 1 | .... | 1 | .... | 10 | 1 | 147 |
| 1938 | 67 | 46 | 37 | 1 | .... | 1 | 1 | 12 | 17 | 182 |
| 1939 | 78 | 41 | 36 | .... | .... | .... | .... | 15 | 17 | 187 |
| 1940 | 87 | 61 | 29 | 1 | .... | 1 | .... | 8 | 23 | 210 |
| 1941 | 118 | 72 | 23 | 3 | .... | 2 | .... | 31 | 4 | 253 |
| 1942 | 131 | 45 | 31 | 1 | 1 | .... | 2 | 35 | 4 | 250 |
| 1943 | 115 | 50 | 46 | 1 | .... | .... | .... | 26 | 6 | 244 |
| 1944 | 125 | 35 | 29 | .... | 1 | .... | .... | 15 | 20 | 225 |
| 1945 | 4 | 1 | 1 | 1 | .... | .... | .... | .... | .... | 7 |
| Total | 937 | 425 | 309 | 12 | 3 | 11 | 3 | 185 | 94 | 1979 |

#### Females

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| 1935 | 46 | 25 | 24 | 4 | 2 | 3 | .... | 12 | .... | 116 |
| 1936 | 51 | 31 | 15 | 6 | 3 | 2 | .... | 8 | .... | 116 |
| 1937 | 61 | 32 | 38 | .... | 2 | 1 | 1 | 11 | 1 | 147 |
| 1938 | 56 | 46 | 29 | 6 | 4 | 3 | .... | 13 | 2 | 159 |
| 1939 | 63 | 44 | 19 | 3 | 1 | 3 | 3 | 8 | 14 | 158 |
| 1940 | 68 | 56 | 19 | 1 | .... | 1 | 1 | 8 | 10 | 164 |
| 1941 | 97 | 42 | 17 | 1 | 6 | 3 | 2 | 7 | 4 | 179 |
| 1942 | 90 | 38 | 29 | 7 | 1 | 5 | 1 | 32 | 1 | 204 |
| 1943 | 93 | 30 | 38 | 2 | .... | 1 | .... | 10 | 7 | 181 |
| 1944 | 87 | 18 | 26 | .... | .... | 1 | .... | 6 | 12 | 150 |
| 1945 | 5 | 2 | .... | .... | .... | .... | .... | .... | 1 | 8 |
| Total | 717 | 364 | 254 | 30 | 19 | 23 | 8 | 115 | 52 | 1582 |

*1944 and 1945 still coming in

## Table VII

### Stage of Disease on Admission

1935-1945*

| | Per cent of total localized | Per cent of total remote metastases |
|---|---|---|
| **Males** | | |
| Over five years | | |
| 1935-1939 Admissions | 45.2 ± 1.77 | 19.0 ± 1.40 |
| Less than five years | | |
| 1940-1944 Admissions | 48.7 ± 1.45 | 13.4 ± .99 |
| **Females** | | |
| Over five years | | |
| 1935-1939 Admissions | 39.8 ± 1.86 | 18.0 ± 1.46 |
| Less than five years | | |
| 1940-1944 Admissions | 49.5 ± 1.69 | 14.7 ± 1.20 |

*1944-1945 still coming in

Survival rates of breast cancer cases by stage of disease on admission follow:

| | 1935-1939 admissions | 1935-1945 admissions |
|---|---|---|
| Localized | 53.1 | 69.7 |
| Regional involvement | 20.0 | 36.7 |
| Remote metastasis | 3.2 | 25.4 |

This shows clearly the greater chance of survival if the patient comes to treatment with the disease localized.

As a matter of further interest in the question of delay, the percentage of individuals coming to the New Haven Hospital for treatment within one month, four months, and six months of first symptoms has been computed. The per cent of those with unknown delay is also given.

Table VIII

Present Status of Breast Cancer Cases by Stage of Disease at Time of Admission by Year

1935-1945*

Females

| | LOCALIZED | | | REGIONAL INVOLVEMENT | | | REMOTE METASTASES | | | OTHERS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| YEAR | LIVING | DEAD | UNTRACED | LIVING | DEAD | UNTRACED | LIVING | DEAD | UNTRACED | LIVING | DEAD | UNTRACED | TOTAL |
| 1935 | 2 | 3 | .... | 1 | 7 | .... | .... | 3 | .... | 1 | 3 | .... | 20 |
| 1936 | 8 | 5 | .... | 2 | 15 | .... | .... | 6 | .... | .... | 7 | .... | 43 |
| 1937 | 5 | 4 | .... | .... | 12 | 1 | .... | 11 | .... | .... | .... | .... | 33 |
| 1938 | 6 | 3 | 1 | 5 | 14 | .... | .... | 6 | 1 | .... | 7 | .... | 43 |
| 1939 | 5 | 5 | 2 | 6 | 7 | .... | 1 | 3 | .... | 4 | 7 | .... | 40 |
| 1940 | 5 | 3 | 4 | 5 | 14 | 2 | .... | 3 | .... | .... | 3 | .... | 39 |
| 1941 | 13 | 3 | 1 | 8 | 8 | 2 | 1 | 3 | .... | 1 | 5 | 1 | 46 |
| 1942 | 16 | 2 | .... | 6 | 5 | .... | 1 | 6 | .... | 2 | 4 | .... | 42 |
| 1943 | 13 | 1 | .... | 9 | 1 | .... | 8 | 6 | .... | 2 | .... | .... | 40 |
| 1944 | 12 | .... | .... | 9 | .... | .... | 6 | 2 | .... | 2 | 1 | .... | 32 |
| 1945 | 2 | .... | .... | 2 | .... | .... | .... | .... | .... | .... | .... | .... | 4 |
| Total | 87 | 29 | 8 | 53 | 83 | 5 | 17 | 49 | 1 | 12 | 37 | 1 | 382 |

*1944 and 1945 still coming in

Table IX

Percentage of Cancer Patients Receiving Treatment Within Selected Intervals of Delay From First Symptoms

1935-1945*

| | MALES | FEMALES |
|---|---|---|
| Within one month | 15.5 | 17.5 |
| Within four months | 37.1 | 35.7 |
| Within six months | 50.0 | 46.6 |
| Unknown | 11.2 | 13.0 |

* 1944 and 1945 still coming in

If the information on delay was questioned or vague, it was classified as unknown. The results show that while more females were under treatment within one month of symptom, more males were under treatment within four months and a still larger proportion than among females within six months. The percentage of unknowns among the females was slightly greater than among the males.

The median delay in months from first symptom to treatment by year of admission to hospital and by sex is given in the next table. The median delay is getting less for both males and females although the tendency is more consistent among males. For males the median duration of delay for the entire period was 7 months and for females 8.5 months. This compares favorably with the state as a whole as reported in 1944.[3]

The last table gives the present status of total cancer cases by site of lesion and by sex for the

Table X

Median Delay in Months From First Symptoms to Treatment of Individuals With Cancer by Year of Admission to Hospital by Sex

1935-1945*

| MALES | | FEMALES | |
|---|---|---|---|
| YEAR | MEDIAN | YEAR | MEDIAN |
| 1935 | 11.2 | 1935 | 7.6 |
| 1936 | 8.9 | 1936 | 9.0 |
| 1937 | 8.4 | 1937 | 12.5 |
| 1938 | 7.8 | 1938 | 12.5 |
| 1939 | 8.0 | 1939 | 9.7 |
| 1940 | 7.0 | 1940 | 6.6 |
| 1941 | 8.4 | 1941 | 7.6 |
| 1942 | 6.6 | 1942 | 6.8 |
| 1943 | 6.5 | 1943 | 7.4 |
| 1944 | 5.8 | 1944 | 7.3 |
| 1945 | ..... | 1945 | ..... |
| | 7.0 | | 8.5 |

*1944 and 1945 still coming in

period 1935-1939 (over five years) and for the period 1940-1945 (under five years). The Nomenclature of Diagnoses in Use at the Memorial Hospital for the Treatment of Cancer and Allied Diseases has been used in this table. From a statistical point of view this is an adequate and satisfactory nomenclature, reducing by its clarity the personal judgment of the individual coding the record to a minimum and consequently reducing the probability of error.

## Table XI

Present Status of Total Cancer Cases by Site of Lesion and by Sex

1935-1939

| Site | Males | | | | Females | | | |
|---|---|---|---|---|---|---|---|---|
| | Living | Dead | Untraced | Total | Living | Dead | Untraced | Total |
| *Skin* | | | | | | | | |
| Skin of Head and Neck | 71 | 36 | 12 | 119 | 40 | 29 | 5 | 74 |
| Skin of Upper Extremities | 5 | 8 | 1 | 14 | 2 | 2 | 0 | 4 |
| Skin of Trunk | 1 | 1 | 0 | 2 | 1 | 2 | 0 | 3 |
| Skin of Lower Extremities | 0 | 1 | 0 | 1 | 4 | 0 | 0 | 4 |
| Skin (generalized, multiple or location not specified) | 5 | 2 | 1 | 8 | 4 | 1 | 1 | 6 |
| *Soft Parts* | | | | | | | | |
| Soft Parts of Head and Neck | 1 | 9 | 0 | 10 | 0 | 5 | 0 | 5 |
| Soft Parts of Upper Extremities | 1 | 1 | 1 | 3 | 1 | 1 | 3 | 5 |
| Soft Parts of Trunk | 1 | 0 | 0 | 1 | 2 | 0 | 1 | 3 |
| Soft Parts of Lower Extremities | 1 | 4 | 2 | 7 | 0 | 1 | 0 | 1 |
| Soft Parts (generalized, multiple or location not specified) | | | | | | | | |
| *Skeletal System* | | | | | | | | |
| Skull (incuding tumors of dental origin) | | | | | 1 | 0 | 1 | 2 |
| Spine (excluding sacrum and coccyx) | 0 | 3 | 0 | 3 | | | | |
| Bones of Upper Extremities, Scapulae and Clavicles | 1 | 1 | 0 | 2 | | | | |
| Bones of Thorax (ribs, sternum) | 0 | 1 | 1 | 2 | 0 | 2 | 0 | 2 |
| Pelvis | 1 | 3 | 1 | 5 | 0 | 1 | 0 | 1 |
| Bones of Lower Extremities | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 |
| Bones of Skeleton (generalized, multiple or location not specified) | 0 | 2 | 0 | 2 | | | | |
| Joints and Synovial Membranes | 1 | 0 | 0 | 1 | | | | |
| *Central Nervous System* | | | | | | | | |
| Brain and Membranes | 0 | 3 | 0 | 3 | 0 | 3 | 1 | 4 |
| *Upper Respiratory and Alimentary Tracts* | | | | | | | | |
| Lip | 30 | 13 | 1 | 44 | 1 | 1 | 0 | 2 |
| Gingiva | 0 | 8 | 1 | 9 | 1 | 1 | 0 | 2 |
| Palate | 1 | 4 | 0 | 5 | | | | |
| Floor of Mouth | 2 | 14 | 1 | 17 | 1 | 0 | 0 | 1 |
| Tongue | 1 | 7 | 2 | 10 | | | | |
| Tonsil | 1 | 3 | 0 | 4 | 0 | 0 | 1 | 1 |
| Nasal Cavity | 2 | 0 | 0 | 2 | | | | |
| Nasopharynx | 0 | 4 | 0 | 4 | 0 | 2 | 0 | 2 |
| Pharyngeal Wall | 0 | 8 | 0 | 8 | | | | |
| Extrinsic Larynx | 5 | 4 | 0 | 9 | 2 | 1 | 0 | 3 |
| Intrinsic Larynx | 4 | 27 | 1 | 32 | 1 | 2 | 0 | 3 |
| Paranasal Sinuses | 0 | 2 | 0 | 2 | 0 | 2 | 0 | 2 |
| Oral Mucous Membranes or Mouth Cavity (generalized, multiple or location not specified) | 0 | 8 | 2 | 10 | 0 | 5 | 0 | 5 |
| *Miscellaneous Structures of Head and Neck* | | | | | | | | |
| Eye, Orbital Cavity and Conjunctivae | 1 | 4 | 0 | 5 | 1 | 3 | 1 | 5 |
| Mastoid Cells and Middle and Inner Ear | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Salivary Glands | 3 | 0 | 1 | 4 | 1 | 1 | 0 | 2 |
| Thyroid and Parathyroid | 1 | 2 | 0 | 3 | 3 | 3 | 0 | 6 |

| Site | Males | | | | Females | | | |
|---|---|---|---|---|---|---|---|---|
| | LIVING | DEAD | UNTRACED | TOTAL | LIVING | DEAD | UNTRACED | TOTAL |
| *Breast* | 1 | 1 | 0 | 2 | 46 | 129 | 5 | 180 |
| *Chest Cavity Viscera* | | | | | | | | |
| Trachea, Bronchial Tree and Lungs | 1 | 78 | 0 | 79 | 0 | 18 | 0 | 18 |
| Esophagus | 0 | 29 | 0 | 29 | 0 | 5 | 0 | 5 |
| *Abdominal Cavity Viscera* | | | | | | | | |
| Diaphragm, Peritoneum, Mesentery and Unclassified Abdominal Tumors | 0 | 5 | 0 | 5 | 0 | 2 | 0 | 2 |
| Stomach | 3 | 72 | 3 | 78 | 1 | 26 | 3 | 30 |
| Liver, Gallbladder and Ducts | 0 | 6 | 0 | 6 | 0 | 15 | 0 | 15 |
| Pancreas | 0 | 9 | 0 | 9 | 0 | 3 | 0 | 3 |
| Small Intestine | 2 | 3 | 0 | 5 | 0 | 2 | 0 | 2 |
| Large Intestine, right | 2 | 6 | 0 | 8 | 2 | 15 | 0 | 17 |
| Large Intestine, left | 6 | 31 | 1 | 38 | 2 | 31 | 3 | 36 |
| Large Intestine (generalized, multiple or location not specified) | 1 | 0 | 0 | 1 | 1 | 1 | 0 | 2 |
| Rectum and Anus | 9 | 40 | 2 | 51 | 3 | 23 | 0 | 26 |
| *Urinary Tracts* | | | | | | | | |
| Kidney | 0 | 3 | 2 | 5 | 0 | 4 | 0 | 4 |
| Adrenal | 0 | 1 | 0 | 1 | | | | |
| Urinary Bladder | 1 | 16 | 2 | 19 | 0 | 6 | 1 | 7 |
| *Genital Tract and External Genitalia* | | | | | | | | |
| Prostate, Seminal Vesicles and Adnexae | 3 | 23 | 1 | 27 | | | | |
| Glans and Foreskin of Penis | 0 | 0 | 1 | 1 | | | | |
| Testis, Epididymis and Spermatic Cord | 1 | 1 | 0 | 2 | | | | |
| Corpus of Uterus | | | | | 1 | 25 | 6 | 32 |
| Cervix of Uterus | | | | | 9 | 64 | 14 | 87 |
| Ovaries | | | | | 2 | 19 | 8 | 29 |
| Vagina | | | | | 0 | 3 | 0 | 3 |
| Labia Minora and Clitoris | | | | | 0 | 0 | 1 | 1 |
| *Systemic Diseases* | | | | | | | | |
| Lymphatic Leukemia | 1 | 5 | 1 | 7 | 0 | 13 | 1 | 14 |
| Monocytic Leukemia | 0 | 2 | 0 | 2 | | | | |
| Myelogenous Leukemia | 0 | 8 | 0 | 8 | 1 | 9 | 1 | 11 |
| Lymphoblastoma (not Hodgkin's) | 1 | 5 | 1 | 7 | 0 | 1 | 0 | 1 |
| Hodgkin's Disease | 0 | 8 | 2 | 10 | 2 | 4 | 0 | 6 |
| Lymphosarcoma | 2 | 5 | 3 | 10 | 1 | 3 | 0 | 4 |
| Reticulum cell sarcoma | 0 | 2 | 0 | 2 | | | | |
| *Metastatic Cancer (generalized) No Primary Discovered* | 1 | 24 | 1 | 26 | 0 | 12 | 0 | 12 |
| Totals | 175 | 566 | 49 | 790 | 138 | 501 | 57 | 696 |

1940-1945*

| Site | Males | | | | Females | | | |
|---|---|---|---|---|---|---|---|---|
| | Living | Dead | Untraced | Total | Living | Dead | Untraced | Total |
| *Skin* | | | | | | | | |
| Skin of Head and Neck | 97 | 15 | 4 | 116 | 71 | 10 | 5 | 86 |
| Skin of Upper Extremities | 6 | 2 | 2 | 10 | 5 | 1 | 0 | 6 |
| Skin of Trunk | 7 | 3 | 0 | 10 | 4 | 0 | 0 | 4 |
| Skin of Lower Extremities | 1 | 0 | 0 | 1 | 3 | 1 | 0 | 4 |
| Skin (generalized, multiple or location not specified) | 2 | 1 | 1 | 4 | 3 | 3 | 0 | 6 |
| *Soft Parts* | | | | | | | | |
| Soft Parts of Head and Neck | 5 | 2 | 1 | 8 | 1 | 3 | 0 | 4 |
| Soft Parts of Upper Extremities | 3 | 1 | 1 | 5 | 1 | 0 | 0 | 1 |
| Soft Parts of Trunk | 2 | 2 | 0 | 4 | 1 | 0 | 0 | 1 |
| Soft Parts of Lower Extremities | 3 | 3 | 0 | 6 | 2 | 0 | 1 | 3 |
| Soft Parts (generalized, multiple or location not specified) | | | | | 0 | 1 | 0 | 1 |
| *Skeletal System* | | | | | | | | |
| Skull (incuding tumors of dental origin) | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 1 |
| Spine (excluding sacrum and coccyx) | 2 | 1 | 0 | 3 | | | | |
| Bones of Upper Extremities, Scapulae and Clavicles | | | | | 1 | 0 | 0 | 1 |
| Bones of Thorax (ribs, sternum) | | | | | 1 | 1 | 0 | 2 |
| Pelvis | 0 | 1 | 0 | 1 | | | | |
| Bones of Lower Extremities | 1 | 1 | 0 | 2 | 1 | 0 | 0 | 1 |
| Bones of Skeleton (generalized, multiple or location not specified) | 0 | 6 | 0 | 6 | 0 | 5 | 0 | 5 |
| Joints and Synovial Membranes | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| *Central Nervous System* | | | | | | | | |
| Brain and Membranes | 14 | 30 | 1 | 45 | 17 | 17 | 1 | 35 |
| Spinal Cord and Membranes | 2 | 2 | 0 | 4 | 1 | 0 | 0 | 1 |
| *Upper Respiratory and Alimentary Tracts* | | | | | | | | |
| Lip | 27 | 2 | 1 | 30 | 2 | 0 | 0 | 2 |
| Mucosa of Cheek | 2 | 0 | 0 | 2 | 1 | 0 | 0 | 1 |
| Gingiva | 6 | 8 | 0 | 14 | | | | |
| Palate | 3 | 7 | 0 | 10 | 2 | 0 | 0 | 2 |
| Floor of Mouth | 5 | 5 | 1 | 11 | | | | |
| Tongue | 6 | 14 | 0 | 20 | 5 | 1 | 0 | 6 |
| Tonsil | 3 | 6 | 1 | 10 | 1 | 0 | 0 | 1 |
| Nasopharynx | 2 | 8 | 0 | 10 | 3 | 0 | 0 | 3 |
| Pharyngeal Wall | 5 | 4 | 0 | 9 | 1 | 0 | 0 | 1 |
| Extrinsic Larynx | 10 | 12 | 3 | 25 | 0 | 1 | 0 | 1 |
| Intrinsic Larynx | 19 | 25 | 3 | 47 | 1 | 1 | 0 | 2 |
| Paranasal Sinuses | 1 | 4 | 0 | 5 | 1 | 2 | 0 | 3 |
| Oral Mucous Membranes or Mouth Cavity (generalized, multiple or location not specified) | 4 | 6 | 0 | 10 | 3 | 2 | 0 | 5 |
| *Miscellaneous Structures of Head and Neck* | | | | | | | | |
| Eye, Orbital Cavity and Conjunctivae | 4 | 2 | 0 | 6 | 2 | 2 | 0 | 4 |
| Mastoid Cells and Middle and Inner Ear | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 1 |
| Salivary Glands | 4 | 2 | 0 | 6 | 4 | 2 | 1 | 7 |
| Thyroid and Parathyroid | 2 | 4 | 0 | 6 | 2 | 3 | 0 | 5 |
| *Breast* | 2 | 5 | 0 | 7 | 123 | 69 | 10 | 202 |
| *Chest Cavity Viscera* | | | | | | | | |
| Trachea, Bronchial Tree and Lungs | 22 | 97 | 1 | 120 | 10 | 20 | 1 | 31 |
| Esophagus | 7 | 25 | 0 | 32 | 2 | 7 | 0 | 9 |
| Mediastinum | 1 | 0 | 0 | 1 | | | | |

| Site | MALES | | | | FEMALES | | | |
|---|---|---|---|---|---|---|---|---|
| | LIVING | DEAD | UNTRACED | TOTAL | LIVING | DEAD | UNTRACED | TOTAL |
| *Abdominal Cavity Viscera* | | | | | | | | |
| Diaphragm, Peritoneum, Mesentery and Unclassified Abdominal Tumors | 1 | 3 | 0 | 4 | 1 | 6 | 0 | 7 |
| Stomach | 25 | 65 | 5 | 95 | 4 | 22 | 2 | 28 |
| Liver, Gallbladder and Ducts | 2 | 12 | 1 | 15 | 1 | 12 | 0 | 13 |
| Pancreas | 3 | 11 | 0 | 14 | 1 | 6 | 1 | 8 |
| Small Intestine | 1 | 0 | 0 | 1 | 0 | 1 | 0 | 1 |
| Large Intestine, right | 9 | 9 | 1 | 19 | 13 | 7 | 1 | 21 |
| Large Intestine, left | 18 | 26 | 0 | 44 | 20 | 11 | 0 | 31 |
| Large Intestine (generalized, multiple or location not specified) | 5 | 3 | 0 | 8 | | | | |
| Rectum and Anus | 30 | 46 | 0 | 76 | 22 | 28 | 1 | 51 |
| *Urinary Tracts* | | | | | | | | |
| Kidney | 10 | 8 | 0 | 18 | 3 | 5 | 1 | 9 |
| Adrenal | | | | | 1 | 0 | 0 | 1 |
| Ureter | 1 | 0 | 1 | 2 | 1 | 0 | 0 | 1 |
| Urinary Bladder | 30 | 20 | 5 | 55 | 6 | 3 | 2 | 11 |
| Urethra | 1 | 1 | 0 | 2 | 0 | 1 | 0 | 1 |
| *Genital Tract and External Genitalia* | | | | | | | | |
| Prostate, seminal vesicles and adnexae | 66 | 31 | 16 | 113 | | | | |
| Glans and Foreskin of Penis | 1 | 0 | 0 | 1 | | | | |
| Testis, Epididymis and Spermatic Cord | 5 | 6 | 3 | 14 | | | | |
| Corpus of Uterus | | | | | 16 | 15 | 12 | 43 |
| Cervix of Uterus | | | | | 54 | 32 | 13 | 99 |
| Ovaries | | | | | 7 | 18 | 7 | 32 |
| Vagina | | | | | 1 | 3 | 0 | 4 |
| *Systemic Diseases* | | | | | | | | |
| Acute Leukemia | | | | | 1 | 1 | 0 | 2 |
| Lymphatic Leukemia | 2 | 5 | 0 | 7 | 0 | 6 | 0 | 6 |
| Monocytic Leukemia | 4 | 1 | 0 | 5 | 0 | 1 | 0 | 1 |
| Myelogenous Leukemia | 1 | 7 | 1 | 9 | 1 | 4 | 0 | 5 |
| Lymphoblastoma (not Hodgkin's) | 3 | 4 | 0 | 7 | 5 | 3 | 0 | 8 |
| Hodgkin's Disease | 9 | 12 | 0 | 21 | 4 | 10 | 0 | 14 |
| Lymphosarcoma | 6 | 7 | 0 | 13 | 0 | 5 | 0 | 5 |
| Reticulum cell sarcoma | | | | | 1 | 1 | 0 | 2 |
| *Metastatic Cancer (generalized) No Primary Discovered* | 8 | 28 | 0 | 36 | 5 | 28 | 0 | 33 |
| Totals | 523 | 613 | 53 | 1189 | 443 | 383 | 60 | 886 |

*1944 and 1945 still coming in

This is the picture as completely as it has been possible to obtain it. It does not select or eliminate. It carries out the first objective, i.e., to find out what the cancer situation is in this general hospital. Certain vague diagnoses could have been omitted, and the resulting picture would have been brighter. It would be a distortion, however. The decrease in number of vague and questionable diagnoses of cancer will be an other criterion of improvement. It is becoming noticeable that the use of the classification, "Neoplasm malignant-doubtful diagnosis—no satisfactory check by x-ray or operation—clinical diagnosis only—possible diagnosis," is diminishing as the patient work-ups become more complete.

This summary would not be complete without an acknowledgement of the constant cooperation and encouragement of the personnel of the Division of Cancer Research of the Connecticut State Department of Health. It was an undoubted advantage to all in the state when the intensive follow-up of all hospitalized cases was promulgated in a specific planned program of accomplishment which began

in June, 1941. The follow-up work of this hospital has been progressively easier to establish since it has been accepted on a state-wide basis as a logical necessity. The cross reference between the cancer record workers in all the hospitals is another advantage. It is now customary for the Division of Cancer Research to send immediately upon receipt the abstracted record from any other hospital of any individual who has been in this institution. In some instances this has resulted in tracing people who have moved about the state without the loss of time and effort that would have been required to trace the case from this hospital directly.

The nation-wide interest in cancer often results in advance notices coming with abstracts of records before the individual patient has arrived in Connecticut. The cooperation in the field of cancer follow-up seems to be complete among workers in the field. The last obstacle to be overcome is the occasional lack of cooperation of the patient.

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# HOW DANGEROUS TO THE COMMUNITY ARE STATE HOSPITAL PATIENTS?

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The therapeutic programs of modern state hospitals place increasing emphasis upon helping the patient readjust to the community as soon as it seems psychiatrically sound. Such programs represent a revolutionary change from the indefinite, sometimes life-long, custodial care of mentally sick persons which was the rule in such hospitals. A serious obstacle in carrying out the programs of readjustment is the community's fear of the patient, a social attitude which has accounted so much for the "stigma" attached to mental illness. Often great pressure is exerted on mental hospitals to keep patients permanently. This pressure may be brought by various members of the community, including the police, whose insistence may be the result of the strain that the community has felt because of a particular patient's behavior or illness before hospitalization. Or, the pressure to keep patients in the hospital may arise from the fear that once a person is mentally sick, he can never be trusted again. Even the best informed members of the lay public have "read in the newspaper" about the horrible crimes committed by "lunatics" who had been allowed to leave a state institution. The staffs of all institutions for the mentally ill know full well how easily a community can become emotionally charged over night because of some patient who "should have been kept locked up." The only way to honestly and intelligently allay the communities' fears is to offer them reliable data on the social records of patients who have been discharged.

In 1938 a study was reported by Pollock[1] of the New York State Mental Hygiene Department to determine the crime rate of patients paroled from the state's mental hospitals. A careful check was made of all paroled patients to determine the number of arrests and the reasons for arrest during a one-year period. It was found that of the 5,833 patients on parole during 1937, only 40 had come to the attention of the police during that year. This represented an average arrest rate of 6.9 patients per thousand patients on parole in 1937. This figure is impressively small, but if it is compared with the overall rate of arrests made in the general popula-

*From the Norwich State Hospital, Norwich, Conn.*

tion of the same state in the same year, it immediately appears that paroled patients have but a fraction of the arrest rate of the average population. The New York Department of Correction reported an overall arrest rate of 99.7 persons per thousand of the state's population in 1937. This would mean that paroled patients got into trouble with the police only one-fourteenth as much as the general public. When the rates of arrests were analyzed for geographical and population area, the data indicated that the paroled patients were arrested only one-fourth to one-fourteenth as much as other persons.

The present report is concerned with a similar study in the State of Connecticut. We wished to determine how many of the patients who left the Norwich State Hospital during a four-year period had become known to the police. This hospital is one of three state mental hospitals in Connecticut, and serves all of the eastern half of the state and the City of Hartford. Our data refer, therefore, only to about one-third of the state's hospital population. All patients who had been transferred here from the Connecticut State Prison and those who were out-of-state residents were not included. Altogether, the records of 1,676 patients who had left the hospital, either "discharged" or "paroled,"[2] during the four-year period, November 1, 1940, to October 28, 1944, were studied. Since the parole period is limited to six months, the patients who were subsequently discharged from parole during the four years were also included.

RESULTS

Of the 1,676 patients who were paroled and discharged (directly or from parole) in the four-year period studied, only 87, or 5.2 per cent of the total number had become known to the local and state police since leaving the hospital. Moreover, 314, or 18.4 per cent of the total number and been known to the police for some cause before their hospitalization. However, this last figure covers such an indefinite period of time that the figure is hardly significant. But it is of unusual interest that all but six of the 87 patients who were in trouble with the law after leaving the hospital were also known to the police before they were committed, while 233 with previous police records had no trouble after leaving the hospital within the time studied.

Table I presents the reasons for arrest of those patients who had been arrested prior to commitment, and also of those arrested after they had been paroled or discharged. Due to the limitations of police records it was not possible to break these data down as to the relative ages of the offenders, although undoubtedly this has a real effect on the type of crime committed. Also Table I compares the arrest rate of the patients studied with the recorded crime rate of the State's general population. It is estimated that the average time that these patients were out of the hospital is two years. The rate of arrest per thousand of these patients can then be compared with a comparable two year period for the general population. For this purpose

TABLE I

ARRESTS OF PATIENTS RELEASED FROM HOSPITAL 1940-1944, COMPARED WITH GENERAL ARREST RATE OF CONNECTICUT IN THE SAME AVERAGE PERIOD

| | ARRESTS MADE ON PATIENTS | | ARREST RATE PER THOUSAND FOR AVERAGE TWO YEAR PERIOD | |
|---|---|---|---|---|
| | BEFORE HOSPITALIZATION | AFTER HOSPITALIZATION | PATIENTS ARRESTED AFTER HOSPITALIZATION | GENERAL POPULATION FOR CONNECTICUT F. B. I.[1] |
| FELONY | | | | |
| Murder | 1 | 0 | 0 | 0.09 |
| Suicide | 2 | 1 | 0.6 | .....[2] |
| Robbery | 1 | 0 | 0 | 0.33 |
| Aggravated Assault | 3 | 0 | 0 | 0.31 |
| Burglary | 4 | 0 | 0 | 6.32 |
| Larceny—theft | 11 | 3 | 1.8 | 16.99 |
| Auto Theft | 0 | 0 | 0 | 3.4 |
| Sex Assault On Children | 5 | 1 | 0.6 | .....[2] |
| Sex Assault (rape, sodomy, bestiality) | 5 | 2 | 1.2 | .....[2] |
| MISDEMEANORS | | | | |
| Prostitution | 18 | 3 | 1.8 | .....[2] |
| Drunk and Breach of Peace | 211 | 67 | 39.9 | 80.0[3] |
| Assault and Battery | 7 | 2 | 1.2 | .....[2] |
| Vagrancy—Non support | 17 | 5 | 3.0 | .....[2] |
| Vice—gambling, narcotics illegal liquor | 11 | 1 | 0.6 | |
| Traffic and City Laws | 18 | 2 | 1.2 | |

[1]Average arrest rate per thousand population in Connecticut for two year period 1942-1943. Figures obtained from the Uniform Crime Reports of the Federal Bureau of Investigation.

[2]Data for Connecticut not included in Uniform Crime Report.

[3]Estimated National Rate published in Uniform Crime Report, Federal Bureau of Investigation, Annual Report, 1943.

the arrest rate of the general population for the years 1942-1943 were used. Since Connecticut has no central index of arrests it was necessary to rely on the statistics published in the Uniform Crime Reports of the Federal Bureau of Investigation. Unfortunately these do not include rates of arrests for misdemeanors within the State.

Such a comparison reveals that the felony rate of patients leaving the hospital is extremely small and significantly lower than the biannual State average for the general population.

One of the most common fears of the community regarding the "crazy person" is that he will attack someone violently, either killing, robbing or assaulting him sexually. Of the 1,676 patients who had left the hospital in this four-year period, only six were charged with acts of violence against property or person. Three of these charges were for theft, and included two charges of "embezzlement" and passing fraudulent checks and one of stealing property. None of these former patients was bound over to the Superior Court, except one embezzler who was fined one hundred dollars.

The other three charges of violence were for sexual misbehavior. In one instance a paroled patient (who had been diagnosed psychosis and mental deficiency) was seen masturbating before two little children. Although the incident was probably disturbing to the children, apparently the patient made no effort to enlist their participation. The patient himself was always so easily supervised at home that his relatives had become lax in their attention, and on their agreement to supervise him more carefully, the charges were dropped by the police.

Another paroled patient, who was arrested, was subsequently sent to the State Prison for rape. He was a schizophrenic, twenty-seven years of age, who was dull, with poor judgment and little initiative. His family had tried to get him to work, but his own efforts in this direction were minimal. For the most part he would merely hang around street corners and go to the movies. He was finally accused of attempted rape by a young waitress who accepted a "pick up" from him and three companions at 2 A. M. She charged that the patient had tried to "proposition" her after driving her home, and that when she refused he slapped her a few times.

The third patient arrested as a sex offender was a young schizophrenic who also had been ill a long time, had become preoccupied in manner and had few social interests. He was a known homosexual and at home became sexually active with a feeble-minded boy in the community. He was finally arrested on a charge of sodomy. He was bound over to the Superior Court, but because of his obvious illness the charges were not pressed.

As might be expected, the majority of arrests are in the misdemeanor group. Although this is also true of the general population rate, a partial explanation for this may lie in the poor judgment of the mentally ill person, or the personality of the psychopath who has little sense of social responsibility. Roughly, the arrests for misdemeanors were ten times greater than the number of arrests for more serious offenses. It is interesting that this ratio should prevail for the group of patients arrested both before and after hospitalization.

Probably a certain number of the arrests made in the group of individuals who eventually come to a mental hospital is the direct result of their mental illness or psychopathy. Once the patient is hospitalized and is released (usually under some sort of supervision) the arrest-precipitating-behavior is either no longer present or is under some social control. For example, a patient who had had some sort of breakdown following the birth of her first child in 1914, developed various paranoid ideas against her neighbors and became abusive toward them. At the same time, she lost interest in her growing family. From 1918 to 1924 she was arrested twelve times. The charges were either breach of the peace, assault and battery, or neglect of children. In 1924 she was committed to a state hospital by a new family physician, although there had actually been very little change in her behavior for the preceding six years. She remained in the hospital for four years, and was then discharged to her family with the statement that she was no better than when she had been admitted and would need to be considered a sick person indefinitely. By this time, the children had grown, and with the help of relatives they began to assume more control over the patient, who has been returned to the hospital twice in the years 1928 to 1942. Her behavior is still markedly paranoid, but there have been no more arrests. The family's acceptance of the fact that the patient was ill seems to have brought about enough change in her situation so that she no longer is troublesome to the community.

Although mentally ill patients appear to have a significantly lower rate of arrest than is true for the community as a whole, we still have a lot to learn about the patients who continue to be arrested.

Many patients who get into trouble with the police after hospitalization as well as before hospitalization are probably inadequately adjusted for reasons which are not directly related to their mental illness at all. It is significant that of all the patients who were arrested after they left the hospital, only six were arrested for the first time. The others seem merely to have been following old anti-social patterns.

It has sometimes been suggested that certain illnesses may predominate among patients who become known to the police. In Table II the formal clinical diagnoses of the 320 patients who were arrested either before or after hospitalization are listed. The data show little significant differences among the clinical groups. As might be expected, the alcoholic group comprise between one-third and one half of all the arrests. There is an even distribution in the number of arrests for the psychotic and the non-psychotic groups, both for those patients who were arrested before hospitalization and those who were arrested after they left the hospital.

Two additional points of interest in these data seem worthy of mention. The incidence of organic psychosis is larger in the group arrested before hospitalization. This may be explained as arising from the confusional episodes and anti-social attitudes common in organic psychoses which might easily lead to difficulties with the police. On the other hand, those patients who leave the hospital with this diagnosis are probably in better social contact or are under the closest supervision, and do not, therefore, come to the attention of the police. The other point is that the number of patients diagnosed as with alcoholic psychosis is significantly higher in the group which has trouble after leaving the hospital. This includes the majority of those patients who had been discharged from the hospital either before they appeared at Probate Court, or were discharged by order of the Probate Court on the termination of the thirty-day emergency commitment. Once back in the community, they quickly resumed their drinking, and often were arrested.

Table II

CLINICAL DIAGNOSES OF PATIENTS RELEASED 1940-1944 WHO WERE ARRESTED BEFORE OR AFTER HOSPITALIZATION

| | DIAGNOSIS OF PATIENTS ARRESTED | | PER CENT DISTRIBUTION OF PATIENTS ARRESTED | |
|---|---|---|---|---|
| | BEFORE HOSPITALIZATION | AFTER HOSPITALIZATION | BEFORE HOSPITALIZATION | AFTER HOSPITALIZATION |
| PSYCHOSIS | | | | |
| Schizophrenia | | | | |
| paranoid | 20 | 4 | 6.2 | 4.6 |
| catatonic | 12 | 5 | 3.7 | 5.7 |
| hebephrenic | 19 | 5 | 5.9 | 5.7 |
| simple | 8 | 0 | 2.5 | 0. |
| undetermined | 31 | 6 | 9.7 | 6.9 |
| Manic-depressive | 9 | 2 | 2.8 | 2.3 |
| Organic | 36 | 5 | 11.2 | 5.7 |
| Psychosis with | | | | |
| Epilepsy | 10 | 2 | 3.1 | 2.3 |
| Mental Deficiency | 19 | 4 | 5.9 | 4.6 |
| Psychopathic | | | | |
| Personality | 5 | 2 | 1.6 | 2.3 |
| NON-PSYCHOTIC DISORDERS | | | | |
| Psycho-neuroses | 6 | 1 | 1.8 | 1.1 |
| Alcoholism | 107 | 41 | 33.4 | 47.3 |
| Drug Addiction | 6 | 3 | 1.8 | 3.4 |
| Psychopathic | | | | |
| Personality | 12 | 4 | 3.7 | 4.6 |
| UNDIAGNOSED PSYCHOSIS | 3 | 0 | 0.9 | 0. |
| NO RECORD | 17 | 3 | 5.4 | 3.4 |

SUMMARY

The police records of 1,676 patients discharged over a four year period from the Norwich (Connecticut) State Hospital have been scrutinized to determine the rate of arrests both before and after hospitalization. From our data it appears that the popular fears of violence or other serious anti-social behavior on the part of persons who have been in a state hospital are generally unfounded. This is corroborated by a similar extensive study made of parolees from state mental institutions in New York state. Therefore, it might be said that these patients who have left mental hospitals are not as dangerous to the community as those who have never been judged mentally ill.

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2. The principal difference between the group of patients who had been paroled and those who had been discharged outright is that the discharged patients usually had not been committed through the Probate Court. They were patients who had been sent to the Hospital on an "Emergency" commitment, but whose symptoms either had cleared up quickly, or had been so mild they were not committed by the Probate Court, even when the Hospital authorities had requested it. Most of this group were alcoholic patients who had been committed during an acute episode of excitement, hallucinosis or delirium tremens, and whose clinical symptoms had subsided. However, the action of discharging this group probably precipitates more criticism than is generally realized. The community sometimes considers the Hospital a dumping ground for its alcoholics, and deeply resents their quick return to the community.

# A NOTE ON SCIATICA, BACKACHE AND INTERVERTEBRAL DISKS

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The recent articles by Dandy[1,2] serve to focus upon the problem of backache and sciatica the attention of general practitioners, surgeons and neurologists. This is, of course, eminently desirable provided the direction of their view does not become warped. There are substantial reasons for the belief that the best fusion of the spine is obtained, as Dandy says, by the removal of the entire disk. In another field (Pott's disease) the proposal recently was made[3] that actual healing requires such a fusion. It was made clear that the use of the word fusion in connection with the posterior bridging operation gave a somewhat false sense of security to the surgeon.

But in his insistence upon the lesion of a disk as the most common cause of backache and sciatica Dandy is on less secure ground. Even though upon operation a disk lesion were to be found in every case of sciatica it would not prove that the disk was, in every instance, responsbile for the symptoms. This must be true because there are too many other causes of backache and sciatica which may be incidentally remedied by the operative procedure.

Two issues have thus been raised by neurological surgery in the field of orthopedic surgery. Both merit the fullest consideration, not only because of their potential merits but also because of their distinguished origin.

Dandy[1] believes that the treatment of defective disks is the same for backache alone and for accompanying sciatica. This consists in the removal of the disk down to bare bone in order to induce a permanent bony ankylosis between the opposing vertebral bodies, thereby preventing recurrences of pain and disability. This proposal has much to recommend it. If it is necessary to remove any part of a disk it would appear to be sound surgical judgment to remove all of it. Ever since the time of Sir Percival Pott it has been known that ankylosis is the objective in the treatment of spinal caries. This was recognized by the originators of spinal bridging operations. The objection to their implementation of the idea lies in the relative inadequacy of posterior bridging as a substitute for ankylosis between the vertebral bodies. In the operative attack upon disk lesions there is, therefore, a logical basis for the complete removal of the cartilage. The fusion thus obtained probably will be firm and it will obviate the need for accompanying spinal bridging and it should, at the same time, serve to prevent recurrences. In the rare event of a return of symptoms it would be realized that a disk was overlooked or that it was not completely removed or that a tumor was present.

In fairness to the spinal bridging operation it must be said that it often is successful when the trouble lies outside of the vertebral bodies and the disks. Failures occur when the bodies and the disks are involved and when for recovery fusion between the bodies is necessary. Under these circumstances the most effective measure may be, as Dandy so forcefully suggests, the complete removal of the disk. The development of this procedure is a logical and commendable outgrowth of his extensive experience with lesions of the intervertebral disks.

This concurrence in the logic of Dandy's suggestions does not mean that the way should at once be opened for the universal application of the procedure. It should, on the contrary, be undertaken with great caution and the outcome in each case should be carefully evaluated. It will require considerable experience before it is known whether the abrupt loss of the disk will not be followed by ill effects from the narrowing of the intervertebral foramina. It may be found that the sudden overlapping of the articular facets may induce traumatic changes which will, in themselves, cause pain and disability.

With the growth of the tendency to look upon the disk as the commonest cause of backache and sciatica there is much room for debate and for disapproval, if not indeed for real alarm, on the part of clinicians. This might be a less hazardous tendency if it were not for the widespread belief that the diagnosis of a disk lesion naturally is followed by an operative attack upon the spine. This simply does not jibe with the great mass of clinical evidence

which clearly shows that only exceptional cases of backache and sciatica fail to recover when treated by adequate conservative measures. But beyond all of this is the well authenticated list of other conditions which are more commonly behind the symptoms of backache and sciatica.

Concerning the assumption that disk lesions must be treated operatively the figures of Grant[4] are illuminating. In a series of ninety-three patients, with a definite diagnosis of ruptured disk, conservative treatment yielded results which compared favorably with those obtained in a companion series in which operation was done. Grant concluded that surgery was not the only treatment for disk lesions. This confirms the validity of observations made before the role of the disk became so prominent in men's minds. These observations show that with rare exceptions sciatica responds to various forms of treatment provided it includes adequate local rest. It is especially significant that the same disorders now being subjected to disk surgery formerly recovered after lumbo-sacral fusions, or posterior bridging.

This suggests that there is in both operations a common element which is primary in importance. Such an element might be the period of enforced bed rest which is common to both procedures. Or it might be the exposure of the spine through an incision which involves considerable soft parts dissection and retraction. In the course of either exposure it might be that areas of fibrosis and muscle spasm are beneficially affected. This likelihood is bolstered by the realization that the commonest group of conditions causing sciatica are found in the fascia, muscle, ligaments and joint capsules.[5] All of these structures frequently are the seat of various forms of fibrositis which is capable of stimulating nerve endings and thus producing sciatic pain. It is especially significant in this connection that fibrositis is favorably affected by just such mechanical measures as those which accompany surgical exposure of the spine.

For this reason it is necessary to keep in mind the possibility that the removal of a protruding disk even when followed by recovery does not by any means prove that the disk was the cause of the symptoms. The present tendency to believe that disks are responsible for any particular proportion of the cases of backache and sciatica is not supported by dependable statistics. Any figures concerning this matter are meaningless and they will remain valueless until they are collected so as to show that no other possibility could have accounted for the symptoms. Until the actual proportion of undoubted disk lesions is known the sensible surgeon will be guided by the realization that there are many other causes of backache and sciatica.

Key[6] recently expressed the view that the patient with idiopathic low back pain with or without sciatica has an intervertebral disk lesion. But even he does not believe that operation is the treatment of choice in more than ten per cent of these cases. The judicious therapeutic approach will, for the present, be influenced by the knowledge that recovery is the rule under constructive, conservative treatment.

These remarks are not intended to encourage sluggishness in the clinical attitude but they are intended to stimulate accuracy in the attempt to understand the nature and the causes of backache and sciatica. Upon this the surgeon must depend for further enlightenment as to the course to follow in the management of this important set of disabling disorders. In the meantime, surgeons may well feel it a duty to consider the complete removal of the disk whenever it is decided to subject it to surgical attack. But it is essential that the diagnosis of a disk lesion should not finally be adopted until the other common causes have been faithfully excluded. It also is to be hoped that even though surgeons do consider the advisability of removing the entire disk, they will not be stampeded into following this course.

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# ELECTRIC SHOCK THERAPY: ITS USE IN A GENERAL HOSPITAL

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THERE is little question but that mental disease is accountable for more morbidity than any other group of diseases. It is a matter of record that more than 50 per cent of all hospital beds are for seriously ill mental patients. Dr. William C. Menninger[1] has recently made the statement that one out of every twenty-two persons is destined to spend at least some part of his life in a hospital for mental diseases because of a psychosis. In addition there are thousands of others, who, without adequate care, are never hospitalized. Looking at the subject in another way, there is probably no type of illness which so baffles the average physician as to how it should be handled. From the point of view of the general public there is no type of sickness which so perplexes the family of the patient. To whom shall they turn? Where shall they send the patient? If it is an earache or a toothache, a cough, a broken arm, a pain in the stomach, the family knows where to go. But if it is a matter of mental illness, the patient's family does not know where they can get help. Shakespeare voiced this rather hopeless appeal for aid in fighting mental illness when he wrote:

"Canst thou not minister to a mind diseased:
Pluck from the memory a rooted sorrow;
Raze out the written troubles of the brain;
And, with some sweet oblivious antidote,
Cleanse the stuffed bosom of that perilous stuff,
Which weighs upon the heart?"

The very magnitude of this problem should be a challenge to the medical profession and to our general hospitals—especially at a time when a great deal of thought is being given to the whole matter of the care of the sick and how it can be improved in the post war world. But what *is* the attitude of our profession and our hospitals today? I would venture to say that 90 per cent of our practitioners of medicine have little or no professional interest in a person afflicted with serious mental disease. Such an individual is to many physicians simply a "headache" who should be gotten rid of as soon as possible. There follows a hasty commitment in a hospital for mental diseases. Often such a procedure is unnecessary and, not infrequently, unjustified. Many of our probate courts aid and abet an unnecessary step by refusing to use the court commitment procedure which the law provides. Our general hospitals, too, are no less anxious to get rid of mental cases. No sooner is the diagnosis of "psychosis" made than the authorities of most of our general hospitals try to get rid of the patient as soon as possible.

But let us look at the matter of confinement in a mental hospital from the patient's point of view. To face the fact of mental illness in a dear one is often more tragic than death itself. It is hard to tell the relatives that death is inevitable but, if one wants to see real grief, let him watch the face of a mother when she is told that her young daughter, at the threshold of adult life, has a chronic mental malady and will probably never be normal mentally again. As one mother, who had cared for her unmarried and originally brilliant schizophrenic daughter for ten years, said, "I would rather see her dead a hundred times." Or watch the face of a husband who is told that his beloved wife will almost certainly commit suicide. Yes, the problem is certainly one that demands real consideration from all of us.

Patients, when they are well enough to realize the situation, dread being sent to a mental hospital and their relatives dread it even more. Again and again come the questions, asked with the greatest anxiety—"Won't she be worse if she is put there with all those crazy people?" "Such terrible things happen in insane asylums. Won't they hurt her?" "How will we be able to face our friends again?" Rightly or wrongly there is a stigma attached to one who has been a patient in a mental hospital and it is true that such a history often prevents one from obtaining employment.

The situation demands that as many cases of mental disease as possible be cared for at home or in our general hospitals. Fortunately the last few years have seen the development of a new therapeutic technique which makes entirely feasible an aggressive and often

*Read before the annual meeting of the Litchfield County Medical Association, Winsted, April 24, 1945*
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successful attack on many cases of mental illness and many of our state legislatures are making plans to enable our general hospitals to acquire the facilities to handle such patients. The technique referred to is the production of convulsions by the use of an electric current and our general hospitals offer an entirely suitable field of operations.

For thousands of years the victims of mental illness were abused and maltreated. Advances in treatment have always lagged behind the treatment of almost all other types of illness. For hundreds of years it was believed that the mentally ill were possessed of devils and they were abused accordingly. For many years they were treated like the lowest criminals—chained to the wall and kept alive on bread and water. Then came that memorable day and that dramatic scene in the last years of the 18th century when Pinel at the Bicetre demonstrated to the Paris Commune that the insane should be treated as sick people and given care and nursing. But in spite of Pinel and Tuke and Dorothea Dix and Clifford Beers and others no effective therapeutic attack was found until 1917 when Wagner-Jauregg treated nine paretics with the organism of malaria. This was the first successful attack on the psychoses and has become one of the recognized treatments for paresis. Fortunately the more successful treatment of early syphilis has cut down the incidence of paressi, which is relatively uncommon today.

But the treatment of schizophrenia and the depressed states still remained and these two psychoses constitute by far the biggest percentage of those committed to mental hospitals. For many years it had been known that a "shock" of some kind at times seemed to benefit patients with schizophrenia. Baldvinus as long ago as 1559 in a book entitled "Miscellanea seu epistolae medicinales" recounts the case of "a young woman of about 25 years who began muttering to herself, flying into passions, seeking solitude, and generally neglecting herself, finally becoming a severe case of melancholia. One day she suddenly jumped out of bed and climbed to the top of a neighboring pillar, from which she fell head foremost on the hard floor below, gradually regaining consciousness. . . . She recovered completely without any medical treatment at all."

It has been observed many times that the behavior of epileptics may become progressively worse until a seizure occurs. This seems to clear the air and behavior improves at once only to become gradually worse again. Some years ago I had occasion to treat an adolescent girl who was both a behavior problem and an epileptic. Her behavior would gradually become worse and worse until it was almost impossible to live with her. Her language would become unprintable. She would cruelly mistreat her younger siblings. Dishes, windows and furniture would be broken. Then would come the grand mal attack—and peace would reign for a time only to be succeeded by a crescendo of bad behavior. It was relatively easy to control the convulsions with dilantin but the mother broke off treatment because, as she said, "I would rather have the convulsions than put up with her terrible behavior." It has been observed that schizophrenia and grand mal epilepsy rarely coexist. If grand mal seizures develop in a schizophrenic, the psychosis tends to clear up. In cases of epilepsy in which schizophrenia develops, the convulsions cease.[2]

In 1933 Sakel[3] reported before the Medical Society of Vienna a new method of treating schizophrenia in which he produced convulsions by throwing the patients into a hypoglycemic state by giving large doses of insulin. In 1935 de Meduna[2] reported the treatment of schizophrenia by producing convulsions with metrazol. Both of these methods have become established procedures in the attack on schizophrenia and both have produced brilliant results at times. Both have decided drawbacks. The use of insulin requires a well trained and experienced team for administering it. It is expensive. The technique is complicated and it is impracticable to use this method outside of a mental hospital. All in all, however, probably better results are obtained with this method of producing conmuch simpler but the patients dread it because of the horror they pass through before they become unconscious. The convulsions produced are so violent that many fractures of vertebrae and long bones have been sustained. At the present time it is less used than the other methods of producing convulsions. Neither of these methods have proved very effective in treating the affective disorders.

In April 1938 Cerletti,[4,5] after first producing convulsions in pigs and dogs with an electric current, produced the first intentional electro-convulsion in man, using an old deteriorated schizophrenic as his subject. The method was first used in this country by Impastato and Almansi.[6,7] It was soon demonstrated that this method of producing convulsions was vastly superior to the insulin and

metrazol methods in many ways. In the first place absolute unconsciousness can always be produced with a subsequent complete amnesia for what has happened. Secondly, convulsions can always be produced. Thirdly, it is a much simpler technique to use. Fourthly, fatalities and serious fractures occur much less often. Fifthly, the convulsion is not so severe as with metrazol and the general physical after-effects, such as general muscular soreness, are not as pronounced. Sixthly, no after treatment convulsions occur as is sometimes the case with metrazol. Seventhly, there is no prolonged coma as occasionally occurs with insulin.

The method is very simple to use. When it has been decided that the patient is a proper subject for electric shock therapy, an investigation is made to determine whether or not he can tolerate the treatment. In general this method can be used safely in the case of anyone under 65 who meets certain general standards. As a matter of fact many people much older than 65 have been treated without any untoward results. People who have decompensated hearts, marked hypertension or nephritis are considered bad risks. A history of pulmonary tuberculosis contraindicates treatment. In people past middle age, x-rays of the spite should be made to make sure that there is no bone disease.

If a patient meets all these requirements, he is prepared for treatment. It is made sure that his stomach is empty and that he has voided. He is then undressed and put to bed. An ordinary hospital bed is used with a board under the mattress. A sand bag is placed under the small of the back so that it is hyper-extended. These two precautions are taken to minimize the chances of the patient sustaining a fracture of a vertebra. A strap is placed over the knees and two or three attendants stand ready to hold the limbs and body when the convulsion occurs. Two electrodes connected with the machine are held in place over the temples by a rubber band which passes around the head and good contact is established with saline jelly. The operator introduces a well padded tongue depressor between the teeth, holds the lower jaw up to guard against a dislocation and presses the switch button. The convulsion ensues immediately.

At the Waterbury Hospital we use an Offner electroshock therapy apparatus, which delivers a sine wave alternating 60 cycle current whose duration and strength may be varied by an electronic device. It is equipped with a safety guard, which makes it impossible to give too much current or for too long a time. The standard practice is to start with a 350 MA current for 0.5 sec. Often it is unnecessary to increase the current or prolong the time. In other cases the amount of current may have to be increased with each treatment.

The objective is to produce a grand mal type of seizure. If the current is insufficient, a petit mal seizure is produced. In this the patient stiffens momentarily, blinks his eyes and appears to be confused for a few seconds. Often he complains of headache and asks where he is. If this occurs, the operator waits for a few minutes, increases the current and again presses the button. The electrically induced convulsion is similar to a natural convulsion. The patient loses consciousness immediately, often utters a cry and stiffens all over. This is quickly followed by the typical clonic phase during which the patient becomes very cyanotic. The convulsion is succeeded by a period of apnea, during which the electrodes are removed, the patient's body and head are flexed and the sand bag is removed. As soon as he is laid back on the pillow he will usually begin to breathe at once and the cyanosis clears up. If this does not occur promptly, an injection of coramine is given. The patient usually lapses into a short period of quiet sleep after which he awakes with complete amnesia for what has happened. Occasionally the period of apnea is followed by a period of violent struggle during which he must be held down. After a varying period—from a few minutes to an hour—the patient has completely recovered and may leave his bed. For the rest of the day he may be somewhat confused and complain of a headache and memory loss.

This method of treatment may be used with outpatients as well as inpatients and most of the patients treated at the Waterbury Hospital have been outpatients. We require that some member of the family come with the patient. After the treatment, the patient is kept in bed for an hour or so, is given lunch and is then allowed to go in the custody of his relative. The method is so simple and so safe that it is now being widely used in practically all mental hospitals in this state and at St. Francis Hospital in Hartford, at St. Raphael's Hospital and the New Haven Hospital in New Haven and at the Waterbury Hospital.

Thousands of patients have now been treated by this method and it is possible to form some conclusions as to its effectiveness. Although insulin-produced convulsions are probably somewhat more effective in combatting schizophrenia, the electric

shock technique is so much simpler that it is usually tried first. No attempt will be made in this paper to give a statistical analysis of its effectiveness as many excellent papers have been written by authors who have large series to report. Suffice to say many hundreds of cases of schizophrenia of recent onset have been cured or greatly moderated by this method.

But it is in the affective disorders that it is the therapeutic method of choice and it is the impression in most of the state's mental hospitals that the period of hospitalization for depressed patients has been reduced by at least 50 per cent. In a recent letter Dr. Edgar Yerbury of the Connecticut State Hospital writes: "The average stay of involutional melancholias who improve sufficiently to leave the hospital is 245 days under other forms of treatment. If one considers only those cases who are able to leave the hospital in one year or less, the average duration is 112 days. For that group, the average stay in the hospital is 63 days, or 40 days after treatment was instituted. In the case of other depressions, the average stay for those able to leave the hospital within one year was 109 days. For those treated with electro-shock therapy, the average stay was 83 days or 47 days after treatment was instituted." Blythewood reports: "We, of course, have found that the duration of illness is reduced very materially with this method of treatment." Reports from other institutions are similar.

The method has been tried in the treatment of the psycho-neurotics, also, but up to the present time it has not proved very successful.

How does the production of a convulsion modify mental disease? Frankly, we do not know. Dr. Foster Kennedy[8] thinks it has some specific effect on the hypothalamus. Dr. Nolan D. C. Lewis[9] compares it to the use of dynamite in breaking up a log jam. Electroencephalographic studies demonstrate that there is a definite, although temporary, change in the brain waves. But we must frankly admit that we do not yet know just what happens.

Is it dangerous? Fatalities are supposed to occur at the rate of about one in one thousand cases[10] but in Connecticut not a single fatality had occurred up until the middle of March of this year although many thousands of treatments had been given. Most of the fatalities have occurred as a result of circulatory failure in already damaged hearts. In properly selected cases fatalities should be almost nil. Does it damage the brain? So far there have been no pathological reports definitely establishing this fact. Dr. Nolan D. C. Lewis[9] has found hemorrhages in the brains of monkeys who have been subjected to much stronger currents than those used in man but has found the same type of hemorrhages in the brains of controls who have not been shocked. We must admit that a large percentage of patients suffer some memory defect but this usually clears up within a few weeks after termination of the treatments. Dr. Foster Kennedy[8] believes that this memory defect is, in the long run, inconsequential. Dr. Stanley Cobb,[11] on the other hand, believes that it is sufficiently serious so that the method should not be used in brain workers except in desperation. But we are dealing with serious and peculiarly heartrending conditions and it would seem that we should not hesitate to use this attack on them any more than the surgeon would refuse to do a laparotomy because of possible unfortunate complications. Several hundred treatments have been given at the Waterbury Hospital with no fatalities and no fractures. One patient sustained a dislocation of the jaw, which was reduced before she recovered consciousness, and one sustained a conjunctival hemorrhage. We know of no cases in which there has been impairment of memory lasting more than a few weeks or months.

Dr. John S. Staneslow and I began using electric shock therapy at the Waterbury Hospital in March 1942. Dr. Staneslow is in the Navy and unfortunately his records are not available for analysis but his results were essentially the same as mine. As of April 1 of this year I have treated 32 individual cases and have given 253 treatments. Most of my patients were schizophrenics or depressed cases of various types. It may be of interest to give a short resume of some of them.

Case I: M. McK., aged 38. This man was seen first on March 22, 1944. He gave a history of a typical schizoid personality who had had an episode similar to the present one about 10 years ago. For two weeks he had not worked because of ideas of reference and paranoid delusions concerned with fears that he "would be taken for a ride." His sister noted that he seemed "to be in a brown study" a great deal of the time and he would talk and laugh to himself. He was afraid that masturbation had "rotted his body away." There was a strong element of depression and he had attempted suicide because of a sense of guilt. He was evidently in an acute schizophrenic episode. He was given 10 treatments during a period of a month and at the end of that time he had lost most of his acute psychotic symptoms. He was cheerful and hopeful and his delusions had ceased. He had taken a job in a gas station. He was last seen on January 23 of this year and he had apparently made a complete recovery.

Case II: L.S., aged 17. This girl was first seen on August 16, 1944. She had always been excessively shy and unsocial. She had always shown a pronounced feeling of inferiority

and had been retiring. During July, after seeing the movie "The Song of Bernadette," she began to think that the Virgin and her patron saint appeared to her and talked to her. She then refused to eat saying that her food was poisoned. There was evidence of autistic thinking and talking to herself. Many other symptoms stamped her as a typical schizophrenic. She was given 15 treatments over a period of six weeks. At the end of that time she had recovered to the extent that she had good insight as to her visions and other symptoms and she was able to resume her work in a factory, where she has carried on steadily ever since.

Case III: D.M., aged 23. This young woman was first seen on November 10, 1944, and she gave a history of increasing mental symptoms for six months. During this period she had had countless injections of some estrogenic substance and had submitted to a tonsilectomy. At the time she was first seen she had almost entirely withdrawn from reality and stayed quietly in bed all day. She would not talk and cried a great deal. She was depressed and did not want to live. She was given 12 treatments over a period of two months. After the third treatment she was talkative and smiling and would get up and dress without urging. At the end of her course of treatments she returned to her work in a factory and has been working steadily ever since.

Case IV: C.G., aged 48. This married woman was first seen on December 26, 1944. She had begun to manifest symptoms of mental disease in October 1944 and had gradually gotten worse. When seen she was completely withdrawn from realty and was in bed. She could not be fed and made no response to any stimulation. She was removed to the hospital and built up with intravenous feedings for three days before receiving her first treatment. She received 11 treatments during a period of 15 days. After her third treatment she began to respond. She was able to leave the hospital on January 11 and came in as an outpatient for her remaining treatments. By January 17 she was apparently entirely normal. She was last seen on February 26 and on that date she was doing her usual housework in her usual way. It is interesting to note that she had another episode diagnosed as schizophrenia in 1939 which was not as severe as this attack. She was treated with insulin at that time and was in the hospital for more than six weeks, a period almost three times as long as this time.

We must consider that the results in all these cases of schizophrenia were very satisfactory as all of them were able to return to their various occupations within a few weeks of instituting treatment. None of them can be considered mentally normal individuals today but they all showed definite symptoms of schizoid personalities before they became acutely ill.

Case V: E.E., aged 37. This married man was first seen on February 8, 1945. He complained of becoming increasingly nervous for a period of more than a year. He was sleeping badly and worrying about every little detail. Nothing gave him any pleasure and he never smiled or showed any signs of affection. There was complete loss of libido. His speech showed marked blocking. He had contemplated suicide. He received 10 treatments during a period of a month. After the third treatment he was sleeping and eating better. After the fifth treatment he was smiling and showed a desire to go to the movies. At the end of his course his affect was apparently entirely normal and he was anxious to return to work. Only his memory defect prevented him from doing so.

Case VI: M.G., aged 53. This married Italian woman was first seen on October 2, 1944. She had been sick for five months and presented a picture of complete dejection. She would spend her time going from one room to another wringing her hands and weeping silently. She had ideas of reference and delusions of guilt. As her heart was fibrillating, she had to be digitalized before treatments were started. She received 9 treatments during a period of three weeks, at the end of which time her recovery was so complete that further treatments seemed unnecessary. She was last seen on February 21. At that time she was apparently normal in every way. She had a complete amnesia for her whole illness and her memory for events of the past three months was excellent.

Case VII: J.R., aged 52. This foundry worker had felt "terrible" for three months. He was exhausted and could not sleep. He was markedly depressed and had contemplated suicide. He was first seen on December 4, 1944, and received his first treatment on December 6. He received a total of 10 treatments and at the end of his course he was cheerful and felt physically well. During his course he was able to continue his heavy work. When last seen on March 29 he felt that he had entirely recovered.

Case VIII: H.B., aged 50. This rural mail carrier was first seen on November 24, 1944. He complained of "nervousness" and inability to sleep. He worried about every thing and felt that he had made some grave errors. He felt exhausted and extremely depressed. He received 8 treatments during a period of three weeks and was able to carry on with his work. After his eighth treatment he refused to come in for any more as he felt perfectly well. He was so cheerful and hopeful for the future that he had given up his job and had started a new business of his own.

Case IX: L.S., aged 49. This housewife was first seen on November 2, 1944. For a period of nine months she had been getting more "nervous." She had developed a marked sense of guilt about a minor flirtation and was extremely depressed. She was unable to do her work and was in tears most of the time. She had thought seriously of suicide. Because she was in the menopausal period she had been given many injections of estrogenic substance without receiving any benefit. She was given 11 treatments during a period of a month and at the end of that time she felt "fine." She had lost most her sense of guilt and was cheerful and interested in taking up her work again.

Case X: H.F., aged 51. This housewife was first seen on November 6, 1944. She had been "nervous and upset" for more than eighteen months and, because of her age, she had been given many injections of estrogenic substance. She had been particularly depressed since August and had seriously considered suicide. She had lost all joy in living and could not do her housework. She was restless and anxious. Smiling was almost impossible. She was given 9 treatments. After the ninth treatment she had apparently

reached her normal emotional state and was anxious to take up her responsibilities again.

It is interesting to note that practically all of these depressed women had received considerable hormone therapy without any benefit. It is my belief that the depressions of the menopausal period have very little direct connection with physiological changes and that the future will see a complete discontinuance of the use of hormones in treating the purely emotional and mental symptoms of this time of life. It will be found that such conditions will respond much better to electric shock therapy.

Case XI: J.S., aged 33. This case of extreme anxiety neurosis was first seen on February 17, 1944. This young man had received a slight injury to his arm about December 1, 1943. As a result he developed a severe spasm of all the muscles of the upper arm. He was hospitalized but no objective evidence of injury could be found. As the pain persisted, the muscles were injected with novocain without relief. He then received a course of diathermy and massage. All the time the pain persisted and he became very anxious and worried about his condition. He developed pains in the neck and paraesthesias up and down the back. He then developed tremors in the affected arm. He felt that he was never going to get well and was not able to sleep or eat. He was extremely restless and paced up and down his room complaining that he was done for and that no one could help him. He received 4 treatments. After the third treatment he felt so well that he asked if he could go horse back riding. He was last seen on February 28, 1944. At that time he had completely lost all his somatic symptoms and he no longer showed any evidence of anxiety.

Case XII: E.S., aged 36. This young man was first seen on December 26, 1944, suffering from a pure case of paranoia. He was sure that his wife had been unfaithful to him. He had gone to all extremes in trying to trap her with some of her supposed paramours. He had accused his factory superintendent of having an affair with her and had threatened to shoot some of his fellow workers. As a result of his mental anguish he could not eat or sleep. He was given 11 treatments. At the end of his course he was willing to admit that he might have been wrong in his suspicions and he stopped his hounding of her and his accusations of his fellow workers. He was able to resume his work and, when last heard from, he was working steadily and efficiently.

In summary may I say that the experiences of psychiatrists throughout the world during the last few years have shown that, in electric shock therapy, we have a potent therapeutic weapon with which to attack many forms of mental disease and particularly schizophrenia and the depressed states, that it is simple to use in properly selected cases, that the danger of immediate harm is insignificant when we consider the results obtained and that permanent impairment of memory is the one long range drawback and this occurs very seldom? With this new form of therapy available our general hospitals should be prepared to treat favorable cases of mental disease and thus cure cases early and spare the patient the pain and humiliation of being a patient in a mental hospital. It can be done and must be done in any hospital which is considered a *general* hospital.

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# THE DISCHARGE OF MEDICAL OFFICERS FROM THE ARMY OF THE UNITED STATES

## A Memorandum to the Board of Trustees of the American Medical Association from the Council of the Connecticut State Medical Society

In 1940, long before the declaration of war, the American Medical Association took the leadership in preparation for medical participation in a national conflict that appeared imminent. At that time the American Medical Association advised each of the component state societies to appoint committees on medical preparedness in order that planning for war might be made within the medical profession. The American Medical Association also conducted a national census of physicians which brought together information concerning the medical profession that must have proved to be of inestimable value during the years that followed.

It was through the efforts of the American Medical Association that the Procurement and Assignment Service for Physicians and Dentists was established by Executive Order of the President of the United States and by the operations of that agency through its Directing Board and state units, recruitment of medical officers to serve with the Forces was carried out in a manner that provided the Services with an adequate supply of medical officer personnel and at the same time, through careful judgment, maintained civilian medical care at a surprisingly high level.

The American Medical Association is to be commended for its foresight, and the service that it rendered to the nation in the present world conflict will ever remain to the credit of the Association.

With the cessation of hostilities in Europe and an announced policy on the part of the Army to reduce its numbers substantially, it becomes evident that the civilian population of the country which has long gone without much of the medical care it desired, expects that the services of a large number of medical officers will no longer be necessary and they will be returned promptly to resume their former occupation. America has been extraordinarily fortunate in being free from widespread illness and epidemic during the years of the war and how long this state of affairs can be expected to last no one can forecast.

In the months that have passed, since capitulation in Germany, the Army has not announced any clear cut policy relative to the separation of medical officers nor has any information been made available to the country as to how many medical officers have been returned to civil life.

It is the opinion of the Council of the Connecticut State Medical Society, acting upon behalf of the medical profession in the state and in the interest of the people of Connecticut, that the American Medical Association, having displayed wisdom and foresight in the recruiting of a medical force, will be doing less than its duty if it does not exert the same skill and influence now in seeing that medical officers are separated from war service with all dispatch and in as large numbers as is consistent with military achievement. It is a matter of common knowledge, believed to be accurate, that there are sixty thousand physicians now serving with the Army and the Navy providing medical care for approximately ten million persons in the Forces. And there are seventy or seventy-five thousand physicians, many of advanced age, remaining to provide medical care for one hundred and thirty million civilians. No question was raised as to this discrepancy of distribution of medical personnel during the period of active hostilities for every person in America wanted the members of the Forces to have the very best possible medical care and they have received it. Now, with the European phase of the war passed, and massed hostilities in the Pacific not certain, the relative lack of medical personnel for civilian care becomes grossly conspicuous.

The Council of the Connecticut State Medical Society urges the American Medical Association to assume again leadership in this field, to press the reactivation of the Procurement and Assignment Service in a workable and liberal advisory authority concerning the separation of medical officers and restore to it the same responsibility it exercised during the period of recruitment of medical officers. Further the American Medical Association and its components should seek the interest of the Congress of the United States in providing a clear and productive separation policy for medical officers in order that civilian medical care strained for three years, be restored as rapidly as possible to the safe and useful level that the patriotic and self-sacrificing people of the United States have a right to expect.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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# EDITORIALS

## Graduate Training in Medicine

The organization of graduate training methods presents itself as a problem not only for recent graduates and returning medical officers but as a necessity for practicing physicians who may wish to further medical training at any time. In the immediate post war period the demand for such training will be especially heavy according to a recent analysis of questionnaires received from 21,029 medical officers. Nearly two-thirds of this entire group expressed a desire to become certified specialists and desired training for this purpose. In addition to this group two out of every five physicians want short (six months or less) review or refresher courses. It is obvious therefore as has been pointed out by A. R. Colwell that beyond the intern level any program of medical instruction must be concerned primarily with two distinct types of instruction in all fields. The first or fundamental type of training is that which is seen in hospital residencies and fellowships. The second is the short review or refresher type used mainly by general practitioners to keep abreast of developments in medicine. Whether the latter type of instruction should be done solely in a university type of institution is debatable. It is important not to confuse these two types of graduate training particularly if they are to be given simultaneously in the same institution.

In the recent report of the Sub Committee on Intern Curriculum of the State Post War Planning Board emphasis was placed on the usefulness of "teaching coordinators." To quote, "The committee recognizes the desirability of a full time physician in the capacity of a teaching coordinator for the intern staff, particularly the larger hospitals and recommends that wherever possible such an official be employed. The committee also suggests the employment of such a full time teacher coordinator by voluntary groups of small hospitals who would supervise the intern training programs in these hospitals." It seems entirely feasible that in addition to these duties such an individual would be in an ideal

position to work out through professional and administrative staffs of hospitals an excellent system of review or refresher courses for the second type of graduate instruction. The Committee of Physicians for the Improvement of Medical Care recognizing the value of such an educational program recently commented that "It is doubtful whether many of these smaller hospitals can afford to support such clinical instructors or will organize their staffs so as to meet the demands of a teaching service." This group further suggests that a national program supported by Federal Funds may be necessary. At the present time the majority of American physicians do not share this committees views on the blessings to be derived from a National Medical Care Program, nevertheless the plans of this committee are prepared to definitely answer the demands for post graduate medical training which at least on paper is far in advance of any concerted effort on the part of so called organized medicine. In our own state much could be accomplished if serious efforts were made to put the plan of the Sub Committee on Intern Curriculum in effect on a relatively wide basis. This would mean, however, a considerable change in attitude on the part of a good many members of hospital professional and administrative staffs, the existence of which does not not at this time show a great deal of evidence.

## Health Regimentation

The following editorial appeared in the *New Haven Sunday Register* July 22, 1945:

The American Medical Association has made a contribution to the cause of of individual freedom through its forthright criticism of the proposed Wagner-Murray-Dingell Bill which would foist upon the people of this nation a tremendously costly system of socialized medicine under a different name. This group of medical men has gone beyond this service by offering for consideration a 14-point program which would provide all of the objectives sought under this bill without the need for increased taxation.

In offering its own logical plan for the extension of the best possible medical care to the people in all communities, the Association pulls no punches in its criticism of this visionary measure which would foist upon the people burdensome and unheard of increases in social security costs and which would place every taxpayer in the hospital construction business. It flatly asserts that any program which would lead to compulsory sickness insurance would lead this country toward "regimentation and totalitarianism." It makes the rightful assertion that the Constitution of the United States, the Bill of Rights and the American way of life are diametrically opposed to any such scheme as this represents.

It must not be overlooked that a vast array of logical thinking economists and fiscal experts have attacked this proposed bill as a dangerous and costly thing. It has been estimated that it will cost one billion, 800-million dollars per year of taxpayer dollars if it were to be enacted into law. This, it is emphasized, represents only a start since it would not include the cost of hospital construction, with such federal institutions scattered willy-nilly about the country. It has also been emphasized that passage of this theory-laden measure would result in

## Are You Missing An Opportunity?

The response to the Society's plan for raising funds for a state headquarters building is now adjudged a success, the goal is in view and the Trustees of the Fund are considering sites and types of construction. The list of those who have subscribed is not as representative as could be desired and a sizable number of our members have not sent in a subscription. This is understandable for in these days there are probably many good reasons why these busy men have just not got around to it. The time has come, however, when in fairness to those who have already subscribed, all of the rest of us should do our part generously. This fund raising plan is in no sense a "drive," no individual solicitation has been or will be made. It is, furthermore, strictly a "family affair" and no funds have been sought outside our membership. This being so, each member who has not sent in a contribution ought to reconsider any reasons for not sharing in this enterprise of the physicians of Connecticut. Those who are managing the building plan are giving freely of their time and effort and indeed of their money to complete this project for all of us. Let us show our appreciation to Dr. Gold and his associates by having the list of contributors truly representative of Connecticut Medicine. Let us do this thing TOGETHER!

jumping the social security costs to employer and employed from one to four per cent.

It must further be remembered that a measure with almost identical objectives was blocked and defeated in the 78th Congress under a storm of protest and oppositon.

As an alternative to this wild and costly plan, the medical group has offered a plan which could be carried through, under their claim, without the need for increased taxation. This certainly should be explored to the fullest extent. It offers improved housing, nutrition and sanitation fundamental to good health, a medical survey in each state, increased voluntary hospitalization insurance and other valuable features.

The plan to have a survey conducted in each state by qualified experts to determine the need for additional medical care is certainly most logical. There can be no need for an orgy of hospital building in states where adequate medical care is already available. It offers a plan for Federal aid to states needing such aid, this to be administered by local authorities. Its many other valuable features would take the public, those who must ultimately pay all such bills, into consideration by an informatory program.

It most logically advocates that any legislation or schemes involving "revolutionary changes" be postponed at this time. Certainly, as this group points out, this is no time to force any socialized medicine scheme upon the country at a time when 60,000 medical men and 12 million men and women are serving their country in a battle to preserve the very democratic system which any such compulsory measure as this now proposed would threaten.

## The Commission on Hospital Care

The rapid growth and unequal distribution of hospitals in this country is a situation which hospital authorities have been considering for a long time. The desire for a coordinated hospital system represents sound planning for the future and with this in mind the American Hospital Association has inaugurated the Commission on Hospital Care, an organization representative of professional and public groups which should be able to do an excellent fact finding job. Beside taking an inventory of the various hospitals, the commission is analyzing economic, geographic and population factors all of which are so important in plans for future development. The Study is financed by the W. K. Kellogg Foundation, The Commonwelath Fund and the National Foundation for Infantile Paralysis. In the plan of procedure the Commission is urging each state through state hospital associations, state health departments and other agencies to make their own surveys. It is only until such surveys are completed that we can know how many and what kind of hospitals we have in America. When we consider the extraordinary development of hospital insurance plans and medical service plans which are daily undergoing great expansion we realize the basic importance of such a detailed survey. Furthermore such knowledge should have a considerable influence on moderating some of the extravagant statements in which some social planners have indulged themselves. Such a survey should be of signal value to our legislators who in seeking such information have been subject to so much misinformation.

## No Clinical Congress

There will be no Clinical Congress held this year, as had been planned, the Society's application to hold this important post graduate medical meeting having been denied by the War Committee on Conventions. Such refusal is almost impossible to understand. How this meeting, attendance upon which would involve practically no rail travel and no hotel accommodations whatever, will prolong the war or endanger American life or interfere with what has become the fetish of small Washington bureaucrats' "National Security," is beyond comprehension. It is doubly hard to know why this thoroughly professional meeting for the purpose of extending medical knowledge cannot be held when untold thousands of people journey each day to the horse tracks. The denial of the Society's application just does not make sense.

## Connecticut Students and Connecticut Internships

Last year the by-laws of our Society were amended to provide student membership for young men and women, residents of Connecticut, who are studying medicine in Class A schools anywhere in the United States. The response to this opportunity on the part of these medical students has been most gratifying and at the present time more than 200 Student Members have been enrolled. As these students approach graduation, it is believed that they may provide a potential pool of recruits for internships in Connecticut hospitals. With this in mind,

our Executive Secretary has recently urged our hospitals to prepare a statement concerning the intern training that they provide for publication in this JOURNAL which now goes to practically all Connecticut medical students wherever they may be. From the records it appears that there are more than 60 Connecticut students who will receive their medical degrees from several medical schools at the end of the next term. No doubt many of these can be attracted to Connecticut hospital internships if they are exposed to the advantages for intern training offered by our hospitals.

## Hospital Internships

*Editor's Note: At the request of the Executive Secretary the hospitals in Connecticut which offer intern service have been asked to furnish a statement regarding such service. These will be published as they are received, the first of which appears herewith.*

THE STAMFORD HOSPITAL
Stamford, Conn.

INTERN SERVICE APPOINTMENTS

Stamford Hospital is a general voluntary hospital with a total of 324 beds including 54 bassinets for become the fetish of small Washington bureaucrats, the newborn. Its intern service includes ward and private service in medicine, surgery, gynecology, obstetrics, eye, ear, nose and throat, pediatrics, isolation for diphtheria and scarlet fever, emergency room, laboratory and clinic service.

During the present emergency the United States Government compels us to give nine months' intern training with a possibility for deferment for another nine months as resident.

Interns are now receiving $100 per month and maintenance. It is expected to continue this payment during the next nine months periods. Applicants are cordially invited to visit the hospital, and to talk things over with some member of our present intern staff.

*Library:* A well stocked library of books and periodicals is available at all times for interns close by their living quarters.

*Recreation:* Tennis and basketball courts are provided on the hospital grounds. A billiard and pool table and ping pong tables are available. Bathing beaches are near by, and are easily available by bus lines.

This hospital is approved for internship by American Medical Association. The institution is situated on a hill about one half mile from the business district and its landscaped grounds cover twenty-two acres. Appointments are now being made for immediate and future service which will begin as soon as men are graduated from the medical schools.

LeRoy C. Brown, Superintendent

HARTFORD HOSPITAL INTERN TRAINING PROGRAM

Monday 5:00 P. M. Cheney Library. Twice per month September through May. Guest speaker of the Hartford City Medical Society presents a clinic for the benefit of the House Staff. (Speakers of national and international repute.)

Tuesday 8:00 A. M. Medical Clinic, Cheney Library —for diagnostic and therapeutic problems with surgical, medical, x-ray and pathology representatives.

Tuesday 12:00 noon. Chest Clinic, Cheney Library. Informal group for study and discussion of diagnostic and therapeutic problems of the thorax.

Wednesday 12:40 P. M. Medical C.P.C., Cheney Library. Medical cases, both living and post mortem, discussed. Cases presented by House Staff and illustrated by slides and blackboard charts. Free and open discussion encouraged.

Thursday 2:00 P. M. Cheney Library (monthly). Teaching motion pictures. Local or out-of-town speakers in selected specialties.

Friday 12:40 P. M. Surgical-Tumor C.P.C., Cheney Library. Surgical or tumor cases, both living and post mortem, discussed. Cases presented by House Staff and illustrated by slides and blackboard charts. Free and open discussion encouraged.

Saturday 9:00 A. M. Surgical clinic—for diagnostic and therapeutic problems with surgical, medical, x-ray and pathology representatives.

Daily training in diagnostic medicine in the out patient department. The out patient department furnishes an additional valuable training to the members of the House Staff as they rotate through this service. Carefully supervised training in the diagnosis of ambulatory patients is provided. Emphasis is placed upon the selective and discriminatory use of x-ray and laboratory facilities in addition to adequate consultative service.

Daily ward rounds by attending staff on medicine, surgery and other specialties.

House Staff Library—Cheney basement. Donated by the Russell Fund. Contains all standard medical textbooks and a practical group of current medical

journals, chosen on the basis of quality rather than quantity. Open 24 hours per day. Books and journals not to be removed from the library.

Interns Handbook. In the interns handbook are listed rules and regulations, hospital procedures and techniques, along with the details of standards maintained by each department.

St. Mary's Hospital, Waterbury

This hospital offers rotating internship with services in: medicine, surgery, gynecology and obstetrics and out patient department. Medical and surgical pediatrics, genito-urinary, orthopedic, ear, nose and throat and ambulance are coupled with other services. Interns are also eligible for a residency. They are allowed full maintenance with uniforms and seventy-five dollars per month. The bed capacity is 387 (327 adult beds and 60 bassinets).

## Major Maurice R. Moore Publishes Research Work

In the May 1945 *News Letter* of the AAF Rheumatic Fever Control Program Major Maurice R. Moore, MC–AUS, (Norwich) publishes the results of research work on the evaluation of antifibrinolysin plasma levels and antistreptolysin titers in Group A streptococcus infections. The summary of his findings follow:

1. Antifibrinolysin blood plasma level determination is a comparatively simple procedure and may be performed in the average hospital laboratory. Approximately 85 per cent of patients with acute respiratory infection associated with Group A streptococcus will develop a positive antifibrinolysin test from five to seven days after the onset. Strongly positive (3 plus to 4 plus) antifibrinolysin reactions occur in approximately 25 per cent of acute respiratory infection cases which carry Group A streptococcus and experience an uneventful recovery.

2. The antistreptolysin blood serum titer determination is a complex procedure requiring special apparatus, special bacteriological media, and specially trained technicians. In a series of 162 patients with acute respiratory infection and who carried Group A streptococcus, two patients were found to have more than 500 units of antistreptolysin. No explanation was evident in one of these cases for this unusual elevation of the antistreptolysin (1,000 units); the other patient was known to have a persistent middle ear infection due to Group A, Type 17 Streptococus.

3. The number of rheumatic fever patients in this series is too insignificant to permit an opinion of the antifibrinolysin and antistreptolysin reactions in such patients. In the four cases studied the antistreptolysin titers increased and receded with the onset and improvement of the patient, whereas the antifibrinolysin reaction failed to follow any definite trend in comparison with the patient's condition.

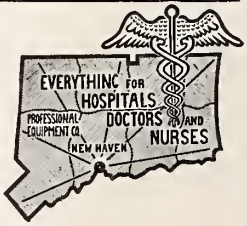
## The Radiology Controversy in Missouri

Missouri has a Medical Care Plan on a cash indemnity basis, payable directly to the physician rendering the service. It is non profit and covers medical and surgical care for hospitalized cases only. Hospital benefits for radiology are limited to diagnostic work only up to $25 per contract year. X-ray and radium therapy are not included.

At a conference of radiologists, pathologists and anesthetists in Missouri, it was agreed that checks for these services should be made out to the physician in charge and the hospital, but preferably the physician alone, who could then endorse the check over to the hospital, until other arrangements could be worked out. The plan now contemplates following the latter arrangements. The Missouri conference came to the conclusion that the physician's name should be placed opposite his charge on the hospital bill—whether for radiology, pathology, or anesthesia—as this procedure is believed to have far reaching beneficial possibilities.




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(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## Surplus Properties for Discharged Medical Officers

New regulations of interest to physicians who will be discharged from the armed forces have been issued recently by the Surplus Properties Board. Regulation No. 7 provides that veterans may apply to the Smaller War Plants Corporation in their district for authority to purchase surplus medical equipment. Property up to the value of $2,500 may be purchased through the SWPC for cash or time payments. Information concerning this procedure is available at the Secretary's Office.

## Committee Meetings

During the month the Committee on Public Relations, the Committee on Industrial Health, the Advisory Committee to the Evaluation Study of Serological Laboratories and the Committee on Radiological Practice in Hospitals have held regular and special meetings.

Dr. Burlingame, the Chairman of the Committee on Public Relations, has announced that that committee will meet regularly on the second Wednesday of each month at the Society offices in New Haven.

## Executive Committee of the Council

The Executive Committee of the Council has conferred by meeting and otherwise a number of times during the month and interim matters have been considered by it.

## Trustees of the Building Fund

The Trustees of the Building Fund met for a regular meeting on August 3 and matters relating to the purchase of a site for the Society's building and architectural plans for the building were discussed. This Board should have important announcements to make in the near future.

## Physicians Recommended for Licensure

The Connecticut Medical Examining Board has announced that the following physicians have been recommended for licensure to practice medicine in Connecticut as a result of the regular written and endorsement examinations held in July 1945.

George C. Becket, Cornell, Lakeville
Sidney Berman, Long Island College, New Haven
Eugene Brody, Harvard, New Haven
Richard J. Brown, University of Maryland, Milford
James L. Callahan, Georgetown University, New Britain
Robert E. Cooke, Yale University, New Haven
Charles H. Crothers, Yale University, New Haven
Donald L. Dunphy, Yale University, New Haven
Malcolm M. Ellison, University of Rochester, New Haven
Robert A. Fox, Creighton University, Danbury
George J. Friou, Cornell, New Haven
Nemo D. Gaines, Illinois, Houston, Texas
Fred M. Haddad, Yale University, Ansonia
Alan L. Hart, Oregon, Hartford
Henry M. Kaplan, New York Medical College, Hartford
F. Douglas Lawrason, University of Minnesota, New Haven
Harriett E. Northrup, Women's Medical College of Pennsylvania, Hartford
Seymour S. Philo, New York University, New York City
Allen I. Saunders, Tufts, New Haven
Frederick W. Shull, University of Rochester, New Haven
Herbert W. Stein, Johns Hopkins, New Haven
Ransom Varley, Albany, New Haven
Kenneth E. Ward, Harvard, Hartford

Also certified to practice medicine:

Joseph T. Calmar, D.O., Philadelphia College of Osteopathy, Stratford

# AN EXCHANGE OF CORRESPONDENCE WITH CONNECTICUT HOSPITAL SERVICE, INC., ON THE INCLUSION OF PROFESSIONAL SERVICES IN THE HOSPITAL PLAN CONTRACT

On July 19 the Council of the Connecticut State Medical Society sent Connecticut Hospital Service, Inc., a letter restating and emphasizing the Society's disapproval of the inclusion of payment for any physician's services under the hospital plan contract as voted by the House of Delegates of the Society. This communication to Connecticut Hospital Service, Inc., developed the following correspondence.

Connecticut State Medical Society
258 Church Street
New Haven, Connecticut

I have your letter of July 19 before me in which you state that you were directed by the Council of the Connecticut State Medical Society to place before the Board of Directors of the Connecticut Hospital Service, Incorporated, a record of the action taken by the House of Delegates and the Council in disapproving the inclusion of payments for professional services under hospital service plan contracts. It is my understanding that the subject of including professional services of certain types as are now furnished by and billed by various hospitals has been discussed with the Connecticut State Hospital Association and that that Association has set forth in some length its views on this subject. I understand that these views were in the hands of the Council prior to the Council's meeting of July 16.

Our contract provides that our members shall be at liberty to select any member hospital to which his physician or surgeon is acceptable, and within the limits of the contract, it provides that such hospital care is subject to the rules and regulations of the hospital selected. In other words, the member patient is entitled to only such services as are normally furnished by the hospital he selects. The Hospital Plans have never dictated or attempted to influence their member hospitals regarding the types of services they furnish. In the particular matter under discussion involving professional services, it has been our contention all along that this was a subject which must be adjusted between the hospitals and the Medical Profession.

There is no indication in your letter that this matter has or has not been adjusted with the hospitals, and in view of that fact it is not clear to me as to just what is the real purpose of your communication of July 19. Am I to construe from this communication that the Connecticut State Medical Society desires the Connecticut Hospital Service, Inc., to revamp its contract so as to exclude these so-called professional services which are now being rendered by the various general hospitals to all of their patients? If this is the intent of your communication, then before placing this matter before our Board of Directors I would feel it quite necessary that I have statements from the Connecticut State Medical Society which would clarify that organization's position on several points as follows:

1. That the Connecticut State Medical Society clearly set forth the reasons for its disapproval of the inclusion of payments for certain professional services as are now provided by the hospitals. The Connecticut Hospital Plan has at present a membership of over 500,000 persons, and is providing hospital service protection to the employees of over 3,500 firms in Connecticut. To modify its contract by eliminating certain services which are now furnished, it must present to these firms and to their employees reasonable justification for the elimination of such services. It is with this in mind that I ask the State Medical Society to prepare such a statement justifying their position in order that such statement may be used if and when a modification of our contract is made.

2. I note in the statement of principles set forth by the Radiological Section of the Connecticut State Medical Society that: "When a single charge is made by a hospital to a private or semi-private patient for radiological service, it be recognized that a portion of that charge represents a fee for professional services and that it is desirable that the professional fee be separated from the charges for hospital service." If this is done, is it the intention of the Connecticut State Medical Society to in any way force commercial insurance companies which now partially or wholly cover such so-called professional services to discontinue that practice? If it is not the intent of the Connecticut State Medical Society to insist upon a modification of commercial insurance contracts, I should then like a statement from the Connecticut State Medical Society which will justify the discrimination against the non profit hospital plans. Former statements to the effect that commercial contracts are on a cash indemnity basis

as compared with the service basis of non profit plans carry no logic as a justification for such discrimination. Commercial insurance companies are continually broadening their cash indemnity plan to the extent that such contracts for all intentional purposes are service contracts. A recent contract offered by one commercial insurance company provides $7 per day benefits plus $70 for extras. Of the two hospitals in the State of Connecticut which operate on the basis of inclusive rates, in neither case do the amounts set for extras in their schedule of rates equal $70. Therefore, any person holding a commercial contract of this type would never pay anything in those two hospitals for extra services such as x-ray and anesthesia.

3. Did the committee headed by Dr. Murdock of Meriden, with which a committee of the Connecticut Hospital Service, Incorporated, held several meetings lack authority to approve of the inclusion in the Hospital Service Contract paragraphs (1) and (2) under Section II-A? These two paragraphs were written in our contract at their suggestion. They are as follows:

1. "Hospital care furnished under this Agreement is to cover services to a member who requires bed and nursing care as a part of his medical or surgical treatment, and is not intended to provide service of a nature which under ordinary conditions would be performed by the physician, surgeon or dentist at their offices or at the member's home."
2. "Professional medical services, that is, service which legally can be performed only by a licensed physician, are not provided under this Agreement. However, when the attending physician of a Member, who is at the time a patient in a Member Hospital orders, within the terms of this Agreement, certain diagnostic and professional services ordinarily furnished by that hospital as a part of its services and billed as a part of its services such as anesthesia, electrocardiology, pathology, and roentgenology, then and only then shall such professional services be covered by this Agreement."

I regret the necessity of requesting from the Connecticut State Medical Society definite answers to the above questions, but if your Society expects our Board of Directors to take such a momentous step as is suggested in your communication, I am sure you realize that they must have before them sufficient evidence to justify action on their part.

I can state without hesitancy that it is the policy of our Board of Directors to cooperate with the hospitals and the Medical Profession in every way possible. The Board must recognize that its first obligation is to its subscribing members. They are the ones who furnish the moneys which make it possible for the Plan to operate and should the day ever come when the Board ceases to carry out these responsibilities, then our non profit Hospital Plan has no justified basis for continuing, particularly as a community service.

Very truly yours,
/s/ Harry B. Kennedy,
Harry B. Kennedy, President

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Mr. Harry B. Kennedy, President
Connecticut Hospital Service, Inc.
152 Temple Street
New Haven, Connecticut

My dear Mr. Kennedy:

Your letter of July 28 requires not only the answer that I can give you now, but a continuing and careful exploration of the subject by all three of the parties interested in furnishing hospital care and the means of meeting some of the costs of medical care: viz; Connecticut Hospital Service, Inc., The Connecticut Hospital Association, and the Connecticut State Medical Society. So vital are our common interests that no pains should be spared to develop services that will continue to give satisfaction to the people of our state.

So many points are raised in your letter which I intend to answer in detail, this communication may appear unduly long, but brevity has been sacrificed for clarity. The numbers refer to the paragraphs in your letter.

Par. 1—Referring to the views set forth by the Connecticut Hospital Association. The lengthy memorandum from that Association was received prior to the Council's meeting on July 16 and had been given appropriate consideration. Most of the proposals in that memorandum were simply restatements of old fixations and the whole was without much merit as viewed by us. In the belief that further efforts to revise hospital-physician relationships in conference with hospital administrators would be fruitless, the Society has expressed itself in a memorandum to the chairman of the board of directors of all voluntary hospitals in Connecticut and to date

has received replies from a number of them stating that this subject would be considered by their board of directors and in one instance it was noted that it was already being studied.

Par. 2—The statement that, "The hospital plans have never dictated or attempted to influence their member hospitals regarding the types of service they furnish," is subject, we believe, to some question and definition of what constitutes dictation and attempts to influence. The medical profession throughout the United States feels warranted skepticism and concern about the continued extension of the influence of Blue Cross Plans in the providing of medical service. Started as they were to provide hospital service and in most instances encouraged and helped by the medical profession, it is common now to find these prosperous plans extending into and encroaching upon areas of special service that certainly were never originally contemplated from them. Specifically in regard to attempts to influence hospitals, we recollect the move, not so long ago, on the part of Connecticut Hospital Service to bring Connecticut hospitals to the acceptance of the all inclusive per diem rate. Perhaps that was not a move toward dictation or influence, but none the less it appeared to be an effort to impose a revision of hospital practice. It was opposed with vigor by the Connecticut State Medical Society as being unsound and a means to encourage unnecessary hospital usage and we are led to believe that the movement was unsuccessful because some Connecticut hospitals, after competent advice by experienced insurance underwriters, declined to enter into contracts with Connecticut Hospital Service on that basis.

In the last sentence of Par. 2, we are willing to agree that the particular matter under discussion is a subject that requires adjustment between hospitals and the medical profession. However, we wish to ask of Connecticut Hospital Service that it not aid in the extension and furtherance of practices which are now considered unfortunate and undesirable by the medical profession.

Par. 3—The answer to the question, "Does the Connecticut State Medical Society desire the Connecticut Hospital Service to revamp its contract," is yes. It is the intent of the Connecticut State Medical Society to continue its efforts to effect a change in the relationships of physicians working in hospitals and it will then be necessary for Connecticut Hospital Service to change its subscriber contracts. We realize this cannot be done at once and that it is not proper for us to ask that you make such a change immediately. However, we do propose that the second sentence of Par. 2, Sect. IIA, of the Rules and Regulations of the Connecticut Hospital Service be deleted and that there be substituted therefor by a separate attachment to the contract at all times a supplemental statement as follows:

"When certain professional services such as diagnostic radiology, physical therapy, pathology, and electro cardiography and anesthesia are ordinarily furnished by a hospital as a part of its service and are ordered by the attending physician of a subscriber when a bed patient in a hospital and billed in the name of the physician performing the service, then, and only then, shall professional services be covered by this agreement."

It is further proposed that there be added to Sect. 3, Par. 3(c) of the Rules and Regulations, "x-ray and radium therapy."

Par. 3—(1) The Connecticut State Medical Society compliments the Connecticut Hospital Service on the great progress it has made and recognized that it has a half-million Connecticut residents covered. The modification of the contract we propose would in no way dilute or limit the benefits these subscribers now receive and our reasons for asking for this change, is to restore the physician, who after all is the only one who can render the service covered, for a hospital cannot, to the position of dignity and individuality that is his right, so that the benefited patient may know that he has received the services of a physician and that what he has been given has not been the automatic product of a complex institution without individual responsibility.

Par. 3—(2) You rightly point out that there should be no discrimination against non profit plans; none is intended. The principle set forth by the Radiological Section of the State Medical Society, "When a single charge is made by a hospital to a private or semi-private patient for radiological service, it be recognized that a portion of that charge represents a fee for professional services and it is desirable that the professional fee be separated from the charges for hospital service," has been approved by the Council of the Connecticut State Medical Society and it is our intent to urge that this principle be adopted by hospitals. Without entering a too lengthy discussion here, it does not appear to us that the matter of commercial insurance contracts which operate almost exclusively on a cash indemnity basis

rather than a service basis are closely related to this matter. Insofar as the analogy drawn with a commercial insurance company contract paying seven dollars per day benefits plus seventy dollars for extras is concerned it seems that this only serves to confuse the issue. If this is a cash indemnity contract, as is likely, with the cash paid directly to the insured, there is hardly any similarity between it and the unlimited x-ray with payment directly to the hospital provided by the contract of Connecticut Hospital Service. In relation to unlimited x-ray service, it might be well to point out here that hospital radiologists believe that provision for such service leads to unnecessary examinations since neither the patient, his physician, or the hospital need be concerned with cost. They present well grounded evidence that this development tends to fill hospital beds with patients undergoing x-ray diagnosis, thereby excluding those whose need for hospitalization is more urgent.

Par. 3—(3) The question asked concerning the authority of the Murdock Committee implies that the inclusion of Pars. 1 and 2 under Sect. IIA of the Hospital Service contract was approved by Dr. Murdock's Committee and has subsequently been repudiated by the State Medical Society. The actual question is, not if the Murdock Committee had authority to give such approval, but did the Murdock Committee give approval of the paragraphs in question? A review of the chronology of events in this connection must be of interest, it is as follows and particular attention is directed to the sequence of dates:

(a) March 10, 1944—The Murdock Committee met on this date and the meeting was attended by Mr. Hoit. During the course of the meeting an informal proposal was made covering the points included in Pars. 1 and 2 of Sect. IIA.

(b) Some few days after this meeting, the wording proposed hastily in the meeting of March 10 was revised and improved in a conference between Mr. Hoit and Dr. Barker.

(c) March 21, 1944—On this date a call for a special meeting of the Murdock Committee was sent out for the purpose of discussion of the wording of Pars. 1 and 2 developed in the conference mentioned in Par. (b) above.

(d) March 28, 1944—It is reliably reported that on this day Connecticut Hospital Service, without the knowledge of the Connecticut State Medical Society or the Murdock Committee, filed its revised contract with the Commissioner of Insurance of the State of Connecticut for approval as required by law and this revised contract as submitted to the Insurance Commissioner included Pars. 1 and 2.

(e) March 30, 1944—On this date the Murdock Committee met and the wording of the two paragraphs was discussed and no action taken. (Note: This was two days after Connecticut Hospital Service had filed its revised contract with the Insurance Commissioner.)

(f) April 4, 1944—By this date the revised contract submitted by Connecticut Hospital Service on March 28 had been approved by the Insurance Commissioner and the new Certificate of Incorporation was issued to Connecticut Hospital Service, Inc., which effected the consolidation with the Hospital Plan of Norwalk.

(g) April 11, 1944—Under this date the Connecticut State Medical Society received a mimeographed copy of the Rules and Regulations of the new subscriber's contract, series A, including the two paragraphs in question defining hospital service.

The matter had been accepted and was concluded and at no time was any formal approval of the wording of these paragraphs furnished to the Connecticut Hospital Service by the State Medical Society. Furthermore, on April 14, 1944, the preliminary draft of the Murdock Committee was circulated among the members of the Committee and that report recommended disapproval of the inclusion of professional services in any hospital plan contract.

The inference to be drawn from these events was inevitable and it was that the Connecticut Hospital Service had pre-determined that certain professional services be included in its subscriber contract and that the wishes, advice, and lack of approval of the State Medical Society were given scant, if any, consideration by Connecticut Hospital Service, because it was clear that the purpose had been adopted by Connecticut Hospital Service and filed officially prior to any action by the Committee representing the State Medical Society.

Par. 4—We too regret the necessity of a request to the Connecticut State Medical Society for definite answers to the questions given above because we are of the opinion that had there been understanding cooperation on the part of Connecticut Hospital Service during the period of these discussions, the questions could have been answered earlier by mutual agreement. With respect to the "momentous

step" in changing the Hospital Plan contract, we suggest that the contract of the Hospital Plan has been changed before, its premium rates have been substantially raised and it is not unlikely that further changes and revisions in the contract may be desirable in the future. The evidence that we put forward in seeking the change outlined in Par. 3 appears to us to be valid in that it seeks to restore and establish the professional status of radiologists, anesthetists, and other physicians who render professional services that are paid for by Connecticut Hospital Service without restricting or denying any benefits now received by subscribers to Connecticut Hospital Service. We hope that in the not far distant future a medical service plan will be established through the mutual efforts and interest of the State Medical Society and Connecticut Hospital Service and an agreement can be reached so that when medical service could and would assume financial responsibility for the payment of these professional services those benefits be withdrawn entirely from the contract of Connecticut Hospital Service. However, before we enter into such close relationships with Connecticut Hospital Service as are inherent in the successful development of the medical service plan, it is well to have these matters understood.

Par. 5—I too can state that it is the policy of the Council of the Connecticut State Medical Society to cooperate with our hospitals and with your organization. History provides a long record of such cooperation with hospitals as is unquestionably demonstrated by the vast amount of free service given to the deserving people of Connecticut in the public wards of hospitals. We believe it is possible through competent local authority to revise some of the relationships now existing between hospitals and physicians employed by them or under working contracts with them. We accept your statement of the policy of the Board of Directors of Connecticut Hospital Service to cooperate with the medical profession in any way possible and we seek your understanding aid in effecting these changes that are highly desirable to our profession. Changes which, in the end, must be of benefit, not only to subscribers of Hospital Service, but to every hospital patient. Our motives have but one objective and that is to improve the quality and status of professional services in hospitals for the help of the sick.

Sincerely yours,
James R. Miller, M.D.,
Chairman of the Council

## The Next Class at Harvard Medical School

Of particular interest at this time when the debate on the supply of physicians and the method of preserving that supply is particularly hot, comes the announcement in the June *Harvard Medical Alumni Bulletin* that that school has approximately 600 applicants for 35 vacancies in the entering class for the fall of 1945. Harvard Medical School will revert to its prewar schedule this year, enrolling its first year class in the autumn and proceeding through four years with summer vacations.

For this autumn class the Army will have thirty-two men and the Navy thirty-four. Fifteen places will be allotted to the Harvard School of Dental Medicine, and ten or eleven will be taken by women. Limiting the class to 125, as the School does, it leaves only thirty-five places for male civilian students.

## U. S. Doctors Banned in Mexico

United States physicians are virtually excluded from practicing medicine in Mexico, *The Journal of the American Medical Association* reports in its June 23 issue. Acording to *The Journal's* Mexico City correspondent, a new and rigid federal law, designed to eliminate foreign influences from the Mexican scientific professions, went into effect on May 28. The law, which lays down a complete system of control for a number of professions, is important in its limitation as far as American doctors are concerned. The statute declares that "no foreigner can practice, in the Federal District and territories, the scientific professions covered by this law." The medical profession is particularly named as one of the fields which has been closed to foreigners.

American physicians already practicing in Mexico, however, probably will not be affected, government sources indicated. These doctors, who comprise some of the country's leading medical authorities, may be required to register their qualifications with the General Bureau of Professions, the government agency which will administer the legislation. Another exception will be made for refugee physicians, who will be conceded "temporary permits" to practice, provided they are able to "prove themselves to be the victims of political persecution in their own country."

# DR. MILLER CALLS ATTENTION TO RHODE ISLAND EXPERIMENT IN MEDICAL CARE

In a letter to the *Hartford Courant* James R. Miller, chairman of the Council of the State Medical Society, calls attention to "some highly illuminating facts developed by Rhode Island's experiment in providing medical care while maintaining the personal relationship between physician and patient." The experiment was undertaken in the town of East Providence and later was extended to include the towns of Warren and Bristol. Preliminary meetings for discussion were held and a booklet describing the program was printed in simple English and sent to every recipient of public assistance, was given to each applicant, and was sent to all medical practitioners in that community and adjacent communities and to the members of the social welfare committee of the Rhode Island Medical Society who also participated in preliminary and subsequent planning.

To quote the bulletin of the Rhode Island Department of Social Welfare:

"The intent of this plan was to foster the usual relationships between recipients of public assistance and medical practitioners in the community. The recipient was not to be deprived of any of his rights or responsibilities for self-direction. He was free to plan the use of his assistance payment as he saw fit and was responsible for selecting and paying for the goods and services which he required.

"For the purpose of this experiment assistance was provided to include the costs of all types of care. All payments made to persons were unconditional money payments in order to enable the recipient to meet the obligations and discharge his responsibilities as he saw fit. Medical need was determined on the advice of competent medical authority.

"Emergency care was always considered to be a requirement, but the decision to supply funds to meet the cost of care beyond the first visit was dependent upon the recommendation of the attending physician. Costs of all services were considered in general on a fee-for-service basis. When recurrent medical expenses could be predicted, they were included in the assistance payment on a cash-in-advance basis. A schedule of fees was established for each service provided within the scope of the plan and represented the amounts which the Division of Public Assistance would consider as cost standards in making the assistance plan. These payments were supplementary to any income or any assistance available from relatives or other sources."

Dr. Miller writes that the experiment was started on January 1, 1944 and the report made on experiences obtained up to March 1, 1945. He states further:

"No complaints came to the state office from any recipient, nor because any care had been denied. The directors of Public Welfare in the three towns were of the opinion that ordinarily this method of payment was very satisfactory. In some instances direct payment to the vendor was more satisfactory in meeting medical care requirements, just as it was more satisfactory in meeting other individual items.

"The medical and dental advisory groups have followed the experiment and though they have recommended some changes, they have indicated a willingness to participate in planning for the entire State on the same basis. The reaction of practitioners was favorable. One said that recipients of public assistance paid their bills better than the general public did. All physicians in all three towns were participating in the program. The report stated in paragraph 6: 'The recipients of public assistance are as capable as any other members of the community, for initiating their own plans, meeting their own obligations and paying their own bills when they have sufficient money to do so.'

"Fifty-eight per cent of the patients were sixty-five years of age or over. In paragraph 8 the report states: 'The average payments in all assistance groups were equal to or less than the state average with the exception of general public assistance payments in one town.'

"In paragraph 9: 'There was no increase in the cost to the State on an overall basis because payments made in this manner are matched by the Federal Government up to certain maxima'."

As Dr. Miller writes in his closing paragraph:

"It is, of course, too early to say whether this experiment will be extended over the entire State with equal success, whether it will be applicable to other States, or whether it will survive a period of economic stress. We shall watch Rhode Island's experience with great interest, just as we are watching the as yet unsuccessful 'Cash-Sickness Compensation Act' which has been in effect since 1942 and which at the present time is running behind at the rate of one million dollars a year."

## Red Cross Gives Iron Tablets to Blood Donors

Since the inauguration of the Blood Donor Service to procure blood for military use, certain Centers have been used as "pilot" Centers to investigate methods pertaining to the taking of blood and to observe the effects of the donating of blood on the donors themselves. Early in the program investigators in the Columbus, Ohio, St. Louis, Missouri, and Detroit, Michigan, Centers began a study on the effects of iron on the regeneration of hemoglobin. These studies have now been completed and soon will be published in detailed form, but we would like to bring a few of the conclusions to your attention at this time. First of all, it is apparent that less than one per cent of male donors have a hemoglobin level of lower than 12.3 grams per 100 cc. of blood, which is the threshold level that we have established for both male and female donors. Practically all of the eligible male donors, that is those with hemoglobin above 12.3 grams, regenerate their blood quickly and almost all of these attain their predonation hemoglobin level in four weeks or less. The investigation of female donors, however, showed somewhat different results. Approximately 10 per cent of women in the 18 to 60 year age groups who appear to make their first blood donation must be refused because they have less than the threshold level of 12.3 grams. Furthermore, those with hemoglobin above this level show a considerable variance in the speed of regeneration after a blood donation. Some form new hemoglobin as rapidly as males but most of them take a longer time and a few will not reach their predonation level by the end of 8-10 weeks, at which time they may have made appointments for another donation. It was the two latter groups that we were particularly interested in and it was found that hemoglobinogenesis was measurably and significantly increased by the taking of even as little as 5 grains of iron daily.

We feel that blood donors have an increased demand for iron that can be in a sense compared to the increased demand for iron known to be present in the last trimester of pregnancy. In the latter it is almost universal practice to prescribe iron to maintain iron reserves and it is apparent that many blood donors likewise will benefit by supplemental iron.

Beginning shortly the American Red Cross New York Blood Donor Center will offer to each female donor an envelope containing approximately one hundred 2½ grain tablets of a ferrous salt. No insistence will be made that they take the tablets and they will be given only to women who have just completed a blood donation. Under no circumstances will iron tablets be distributed to anyone who is rejected as a donor because she fails to meet our hemoglobin standard. Objections may be raised by women who have donated previously but they will be, as in the past, referred to their own physicians.

The following is a copy of the inscription on the envelope which the donor receives:

TO BLOOD DONORS

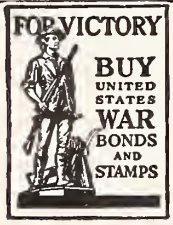
As millions know from experience, healthy adults can donate a pint of blood every eight weeks without impairing their health in any way. The body soon replaces the blood given which is composed principally of fluids, proteins, and red blood cells containing iron. All these are obtained through a normal diet, with the occasional exception of iron.

Recent studies conducted by the Blood Donor Service, however, demonstrate that addition of iron to the diet of women donors usually *speeds* replacement of the red cells, just as salt tablets on a hot summer day speed the replacement of salt lost through perspiration. Accordingly, enough iron tablets to replace the amount of iron in a pint of blood are now being given to donors desiring them.

Those wishing to take them should take one tablet before breakfast the *first* day following the donation; one before breakfast and one before lunch the *second* day; and one before each meal the *third* day and thereafter until all the tablets in this envelope have been used.

Mary Heiss Boynton, M.D., Physician-in-Charge Red Cross Blood Donor Service, New York, New York.

Henry S. Blake, Lt., (MC) USNR, National Technical Director Blood Donor Service American Red Cross.




PROFESSIONAL HEADACHES: — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.




(SEE PAGE 2)

# MEDICINE AND THE WAR

## A U. S. Army M. C. Convalescent Camp in China

Kunming, China—At the U. S. Army Medical Corps' convalescent camp, located on a lakeshore some miles from this city, skilled remedial therapeutic treatment and exercises are hastening the recovery of American troops in the China Theater following hospitalization for battle injuries, major operations, fractures and other casualties.

Under the direction of Major Clinton C. Millett, Omaha, Neb., officer in charge, Capt. Julius R. Pearson, Miami Beach, Fla., medical officer, and Lt. Ben Rubin, Baltimore, Md., physical training director, the convalescent camp is an ideal vacation spot—just the sort of place to go to recuperate.

The site of the camp is the summer home of a Chinese general, nestling between towering mountains and a clear blue lake. Recreation facilities, good food and good companions add to its attraction. The staff of highly trained officers and men see that the camp runs smoothly.

With improvisation as the keynote, a complete remedial therapy gymnasium has been constructed to provide speedy rehabilitation for every conceivable type of injury and post operative case under the supervision of Capt. Pearson and Lt. Rubin. T/3 Edward I. Lantz, 618 South Sixth Street, Philadelphia, is the instructor for remedial therapy. Under his guidance the camp staff, aided by the convalescents, has constructed such reconditioning machines as wall pulleys; stall bars; finger, wrist, shoulder, and leg machines; weight lifting sets; and many other devices to hasten recovery of injured muscles and limbs. Others, such as a rowing machine, are in process of construction.

All the equipment has been built from salvaged materials. Parts of wrecked airplanes and jeeps, scrap metal and lumber, old steering wheels from trucks, tin cans, pipe and concrete; all these are used in the construction of machines.

In line with the most modern medical practice and theory, patients are being released from hospitals soon after they are well enough to get out of bed and are being sent to the convalescent camp for further treatment. Patients operated on for hernia and appendectomy are sent to the camp within a week to ten days after the operation. Fracture cases go to the camp while still in the cast. Battle casualties and other wounds are also sent to the camp as soon as possible.

In the few weeks that the camp has been in operation, it has proved its worth. In China, men, no less than supplies, are at a premium and must be economized. Remedial exercises have been able to return men with serious injuries and operations to duty weeks and even months sooner than was possible in the past.

Sgt. Lantz has had much experience in remedial therapy work with such cases. Formerly a student at the University of Pennsylvania, he did some body building work in civilian life. In July, 1944, he went to Camp Grant where he took the instruc-



Kunming, China—T/Sgt. Harold S. White, Auburn, Me., reconditioning Sgt. Major, watches two of the convalescents at work on their remedial exercises. Pfc. James P. Garner, Rogersville, Ala., right, is building up strength in an injured wrist on the improvised wrist machine. Pvt. Marvin Chan, New York, second from right, is exercising leg muscles on the stall bars.

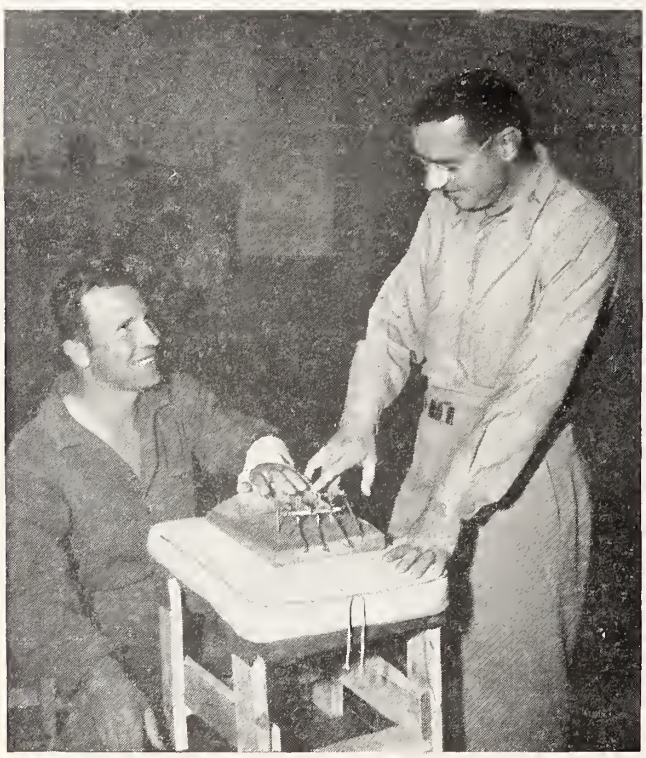
tors' course in reconditioning and rehabilitation. From Camp Grant he went to Lovell General Hospital where he worked with paralysis cases, psycho neurotics, and battle casualties. He came overseas in January, 1945.

Postoperative cases come to the camp as soon as the incision has closed. Sgt. Lantz starts them with exercises for arms and shoulders, for legs and hips, or for other parts of the body not affected by the operation but deprived of their proper usage by days in bed.

Together with these exercises, there are still others specifically designed gradually to strengthen the muscles cut or separated in the operation.

Fracture cases often find that after months in a plaster cast they have partially lost the use of the injured members. Sgt. Lantz, by means of various remedial exercises, gradually strengthens weakened muscles and restores them to their natural function, starting while the cast is still on.

Complete gymnasium equipment is required adequately to treat the many cases calling for remedial therapy. Such equipment is unobtainable in China, so Sgt. Lantz sets to work improvising. The convalescents themselves have helped to build equipment. A finger ladder was built out of scrap lumber for a convalescent with a shoulder injury which kept him from raising his arm higher than his waist. This convalescent after a couple of weeks can raise his arm above his head and is helping in the construction of a machine to rehabilitate legs weakened by long immobilization in a cast.



Kunming, China—Major Clinton C. Millett, Omaha, Neb., officer in charge of the convalscent camp, supervises the workout of Cpl. Ernest E. Powell, Pametto, Fla., on the homemade finger exerciser. Cpl. Powell was hospitalized with a wrist injury.



T/3 Edward I. Lantz, Philadelphia, Pa., left, physical training instructor in charge of the remedial therapy group at the U. S. Army Medical Corps Convalescent Camp, instructs Pfc. R. J. Pate, Columbus, Ga., in the correct use of the wall pulleys. Although Pate's leg is still in a cast. Sgt. Lantz is giving him exercises which will keep the rest of his body in trim.

Important too, is the psychological aspect of the convalescent camp. Every effort is made to see that the convalescent enjoys himself. Good food, beautiful location, recreational facilities contribute to this enjoyment. The convalescent is given confidence in himself. His mind is kept off his sickness. Almost before he knows it, he is out walking around without crutches, playing volleyball or basketball within a few weeks after an appendectomy, or plaiting a belt with a seriously wounded hand.

One convalescent spent three and a half months in a cast with a femur fractured in a plane crash. For a time he was given exercises for the upper part of his body to keep his arms, shoulders, and trunk in condition. Within a matter of days after the cast

was removed, although he had virtually lost the use of the injured leg, he was walking without crutches. Exercises on a stall bar—improvised from lengths of bamboo—are helping rehabilitate the leg. Other exercises will have the man back to duty in record time.

Another convalescent had a bad cut on the inside of his wrist which resulted in the stiffening of his hand and fingers. After two weeks at the camp he has regained almost complete use of the hand. He took exercises on a homemade wrist machine and on a finger exerciser improvised of airplane parts and rubber bands.

## Major E. H. Truex, Jr., Cited For Helping War Deafened

Major Edward H. Truex, Jr., East Hartford, has been awarded a citation on behalf of the aural rehabilitation section of the Army's Deshon General Hospital. The citation, which was presented to Major Truex as chief of the section, was from headquarters of the Third Service Command in Baltimore, Md., for "Excellent quality of work with a minimum amount of lost time and the economical use of personnel, materials and equipment," and was signed by Brig. Gen. T. B. Catron.

Major Truex heads the rehabilitation for the hard of hearing and deafened section at Deshon which is the largest service of its type known to exist today. Recently visited by Col. D. S. McEachern, representing the director general of the Canadian Army's Medical Service who is using the result of his study of Deshon's department as a guide for similar plans in Canada, McEachern stated, "Deshon has the most enlightened program of its kind in the country in its work with the hard of hearing and deafened. Its work will prove to be a standard for such work in other countries."

Major Truex, a graduate of Dartmouth College and the Harvard Medical School, has been in the Army for three years, coming to Deshon from Walter Reed Hospital in Washington where he was associated with the first plans of the Army to cope with the deafened soldier.

## Captain John C. Allen To Be Retired

Col. H. C. Chenault, commanding officer, announced August 7, that Captain John C. Allen of North Haven, chief of physio-therapy of the AAF Regional and Convalescent Hospital, Miami District, will proceed to Drew Field, Tampa, Florida, to meet an AAF medical board for retirement from active duty.

Captain Allen, in the past two and a half years, has helped restore complete strength and movement to injured arms and legs of hundreds of combat veterans. He was appointed physio chief when the AAF hospitals here were placed under Personnel Distribution Command, Miami District, January 1.

Most patients who came here with nerve injuries, broken bones and paralyzed bodies, and who expected little recovery, overcame their difficulties and recovered through physical therapeutic treatments prescribed and administered by Captain Allen and his staff.

He came to Miami Beach from North Haven in January 1943, where he attended AAF Medical Officers' Training School. When the Biltmore unit of the present AAF Regional and Convalescent Hospital was activated the following March, Captain Allen set up the physio-therapy department, which has also been installed at the Nautilus and Tower-Gulfstream units on Miami Beach.

In preparation for wounded returnees here, the therapist took a rehabilitation course at the Institute for the Crippled and Disabled in New York City, soon after this hospital was opened.

Captain Allen practiced medicine in North Haven, where he plans to return, and he also received special training in physical therapy from the well known therapist, Dr. Harry Stewart. A Brown University pre-med graduate, the captain earned his medical degree from Hahneman Medical College in Philadelphia and interned at the college's hospital.

## Bradley Field On Inactive Status

The War Department on August 30 placed Bradley Field Army Air base at Windsor Locks on temporary inactive status. Only a caretaking force necessary to keep the field in stand-to status will be maintained. Bradley Field has been used since May 22, 1945 for the redeployment of combat crews and aircraft from the European and Mediterranean theaters. Under this program a total of 3,456 Liberators, Flying Fortresses and transport planes had landed there up to August 9. These carried a total of 58,563 officers and men.

# MEDICAL OFFICERS' DISCHARGE TO BE BASED ON POINT SYSTEM

The Office of the Surgeon General, U. S. Army, has announced, as reported by *The Journal of the American Medical Association*, a point system for the discharge of medical officers.

The August 11 issue of *The Journal* says that the separation plan of the Surgeon General, drafted after several months work, had to deal not only with numbers but also with classes of personnel.

"On the basis of detailed studies," the Surgeon General's announcement said, "it was decided that it would be best to establish two classes—one for scarce specialists, the other for non-scarce specialists and general duty officers—and to set a definite score for each, so as to keep under strict control the outflow of scarce specialists."

The list of scarce specialists was kept to a minimum, the announcement said, after a review of world-wide requirements and availabilities.

To deal with the separation problem for medical officers, the Surgeon General established a representative Separations Board. It developed "a series of objective criteria, which would insure the continuation of high medical standards during the Pacific war and, at the same time, provide an equitable basis for the separation of surplus officers." The Deputy Surgeon General was designated Chairman of the Separations Board, and representatives of the three major forces—Army Air Forces, Army Ground Forces and Army Service Forces—were made members of the Board.

The Board decided to establish definite criteria for separation subject "to the limits of military necessity which governs all discharge policy." It stressed the fact, however, that "these criteria create no vested right in any officer to discharge, but constitute the goal to be sought," then added: "Such necessity may arise from the possible need for a relatively few officers with irreplaceable experience whose usefulness is so great as to transcend individual consideration."

The criteria for separation from service follows:

1. Medical Corps officers returned by a theater or declared surplus by a major force (except those with primary military occupational specialties listed in paragraph below) are eligible for release from active duty if their Adjusted Service Rating is 100 or above.

2. Medical Corps officers in certain scarce military occupational specialties are eligible for release from active military duty if they have an Adjusted Service Rating of 120 or more: Gastroenterology, Ophthalmology and Otolaryngology, Cardiology, Dermatology, Allergies, Anesthseia, Neuropsychiatry, Neurosurgery, Thoracic Surgery, Plastic Surgery, Orthopedic Surgery, Clinical Laboratory.

3. Medical Corps officers over 50 years of age, irrespective of their specialty classification, are eligible for relief from active military duty if they are returned to the United States by a theater or declared surplus by a major force.

4. No Medical Corps officer with an efficiency index of 41 or more who desires to remain on active military duty will be relieved, irrespective of age, military occupational specialty or Adjusted Service Rating.

The Board explained that paragraph four is "in keeping with the spirit of readjustment regulations which provide that individuals who desire to remain on active duty will be given every consideration."

Continuing, the announcement said:

"Because of the fact that the general hospitals in the United States are now at peak and because the Surgeon General desires to send replacements to the Pacific as quickly as possible, the age provision is not being put into effect at the moment for personnel in the Army Service Forces, and *no Medical Corps officers in the non-scarce category is being released who has less than 110 points (except those who returned from overseas since V-E Day)*. However, it is hoped that when more of the surplus personnel is returned from the European and Mediterraenan theaters, this temporary expedient can be lifted.

"Subject to the general qualifications stated, Table 1, below, summarizes the criteria for separation established for all Medical Department Corps:

TABLE 1—*Criteria for Separation*

| *Corps* | *Age* | *A.S.R.* |
|---|---|---|
| Medical Corps* | 50 or over | 100 or over |
| Dental Corps | 45 or over | 100 or over |
| Medical Administrative Corps | 45 or over | 90 or over |
| Sanitary Corps | 45 or over | 90 or over |
| Veterinary Corps | 50 or over | 110 or over |
| Army Nurse Corps† | 40 or over | 65 or over |
| Physical Therapists Corps† | 50 or over | 65 or over |
| Medical Dietitians Corps† | 50 or over | 65 or over |

*Scarce categories, A. S. R. 120.

†The following additional provisions cover separations: dependent children under 14; married to demobilized allied personnel.

"As in the case of Medical Corps officers, the Army Service Forces, for the time being, have not placed into effect the age provision for Dental Corps officers, and they are operating under a score of 110. But it is hoped that this exception can be removed later."

"To implement the restaffing of units scheduled for the Pacific coming through the United States," the announcement said, "a complete census was undertaken of all personnel stationed in the United States. On the basis of this census and in light of experience to date, criteria were established for withdrawing personnel from units passing through the United States and for assigning personnel now in the United States to the units scheduled for the Pacific.

"These are only general rules and are subject to exception in any case due to military necessity, and to change if subsequent developments should make such action necessary. They are not to be understood as creating any right in an officer to continue on duty in this country if military needs now or later should require his assignment to other duty. Subject to these qulaifications, the plan for withdrawal of officers from units and for new assignments is shown in Table 2.

"Because there is nothing in this plan of medical redeployment which takes precedence over considerations of military necessity, it will not be possible to apply the withdrawal principle to Commanding Officers and Executive Officers of hospital units or to certain Medical Department personnel attached to divisions because adequate replacements cannot be found and trained within the available time."

The text of the official announcement published in *The Journal* said that "during recent weeks every effort has been made to speed the return of surplus personnel from the European and Mediterranean theaters so that a maximum number of Medical Department officers, especially Medical Corps officers, can be returned to the United States for reassignment and separation."

Commenting editorially on the hasty action taken by various medical societies and organizations regarding separation of medical officers, *The Journal* said:

"The policy presented in this issue of *The Journal* is one on which the officials of the United States Army and of the Army Medical Department have been working for some time. . . . The organization known as the Association of American Physicians and Surgeons, Inc., according to the press, has sent a resolution to numerous officials of the government. This resolution lists a number of rumors, most of which are without the slightest foundation in fact. The officials of the Association of American Physicians and Surgeons could have found out how completely unwarranted these statements were before giving them publication and thus promoting dissatisfaction and disintegration of morale without the accomplishment of any conceivable worthwhile objective."

Table 2—*Plan for Withdrawal and Assignment of Officers*

| | AGE | | A. S. R. | | OVERSEAS SERVICE V-E DAY (MONTHS) | |
|---|---|---|---|---|---|---|
| CORPS | WITHDRAWAL | ASSIGNMENT | WITHDRAWAL | ASSIGNMENT | WITHDRAWAL | ASSIGNMENT |
| Medical Corp | 45 or over | 44 or under | 75 or over | 74 or under | 12 | 0 |
| Dental Corps | 40 or over | 39 or under | 50 or over | 49 or under | 6 | 0 |
| Medical Administrative Corps | 40 or over | 39 or under | 50 or over | 49 or under | 6 | 0 |
| Sanitary Corps | 40 or over | 39 or under | 50 or over | 49 or under | 6 | 0 |
| Veterinary Corps | 40 or over | 39 or under | 50 or over | 49 or under | 6 | 0 |
| Army Nurse Corps | 40 or over | 39 or under | 30 or over | 29 or under | 6 | 0 |
| Physical Therapists Corps | 40 or over | 39 or under | 30 or over | 29 or under | 6 | 0 |
| Medical Department Dietitians | 40 or over | 39 or under | 30 or over | 29 or under | 6 | 0 |

## Old Farms at Avon, Connecticut, Receives Meritorious Award

The Old Farms Convalescent Hospital (Special) at Avon, Conn., has been awarded the Meritorious Service Unit Plaque for its work with the blinded soldiers. In making the award Major General Norman T. Kirk, Surgeon General of the Army, said, "The Old Farms Convalescent Hospital (Special), first established in June 1944, quickly developed into an institution unique in its kind in the country, even in the world. Ably administered, the institution

has taken over the important problem of social adjustment of the blinded soldier, and in these relatively few months, has succeeded in its purpose admirably."

## Policy On Assignment of M. C. Officers To Veterans Administration

Additional U. S. Army Medical Corps officers will not be assigned to duty with the Veterans Administration unless they had previously been serving on the staff of that organization, Major General George F. Lull, Deputy Surgeon General of the Army, announced.

In outlining this War Department policy General Lull stated that in the event officers specifically requested service with the Veterans Administration they would be eligible for such assignments.

## ETO Patient Evac Job Nearly Done

More than 100,000 sick and wounded soldiers were returned from Europe between V-E Day and July 31, it was disclosed recently by Brigadier General Raymond W. Bliss, Assistant Surgeon General of the Army.

The Army set for itself a goal of returning by plane and ship all transportable wounded from Europe within 90 days after V-E Day and the record job was completed before the August 8 deadline. In the last war thousands of wounded awaited transportation from Europe for a year.

The number of non transportable cases is comparatively small, General Bliss pointed out, and these will be transported to the U. S. as they are able to be moved.

A streamlined policy of processing wounded returnees has been in effect and the patient is permitted to visit home with an absolute minimum of delay. The majority of the men have arrived at New York City or Charleston, S. C. In a matter of hours within their arrival they are assigned a bed at a nearby hospital, such as Halloran at New York or Stark General at Charleston.

Surgeon General Norman T. Kirk has directed that the patient be sent from these port of debarkation hospitals to a hospital where he can get best medical and surgical care according to his needs. Amputation cases, for example, are sent to any of the seven general hospitals which speciailze in this field, and deaf patients are sent to Borden in Oklahoma, Deshon in Pennsylvania, or Hoff in California.

At the time of Pearl Harbor there were approximately 15,000 beds in all Army general hospitals in this country. That capacity is now 215,000 and does not include the vast network of Army station and regional hospitals which provide for routine needs of soldiers stationed in this country.

## Health of Troops Here Is Excellent

During this past winter and spring the health of troops stationed in the United States has been excellent, surpassing that of any previous war year. The low hospital admission rate for all diseases reflects fewer communicable conditions, as it is during this period of the year that infectious diseases usually predominate.

There were less respiratory diseases than in any previous war year, although during May there was a slight rise in these cases. Pneumonia, measles, scarlet fever, meningitis, and rheumatic fever were all less prevalent than during the winter and spring of 1944. The only important infectious diseases of which this was not true were venereal diseases and infectious hepatitis.

Relapses in the United States of malaria infections acquired in tropical areas overseas increased each month until March 1945, but have since declined slightly. With malaria control in all overseas areas now greatly improved, the number of relapse cases should continue to decrease.

The fact that most of our troops are well seasoned and there are fewer newly inducted troops is responsible in part for this improved health record. Most Army hospital beds here are now occupied by patients evacuated from overseas.

## Orthopedic Footwear Clinic

An orthopedic clinic has been opened at the Boston Quartermaster Depot to supply scientifically designed lasts for shoes that will be specially built for soldiers who have suffered foot injuries in line of duty. Details of the Clinic were worked out jointly by the Office of The Quartermaster General and the Office of The Surgeon General which has assigned an orthopedic surgeon, Major Saul S. Steinbergh, MC, to the Clinic.

A recent "spot check" of general and regional hospitals showed that about a thousand patients are in need of special footwear and many of these will require orthopedic shoes as long as they live, according to Colonel Leonard T. Peterson, chief of

the orthopedic branch, Office of The Surgeon General.

Requirements from which the special shoe lasts must be made are very exacting. A newly invented cast making machine, which assures a scientifically accurate mold, has been installed at the Clinic and courses are now being given in its operation. Attending these courses are enlisted orthopedic mechanics from ten hospitals where similar machines will be installed. These hospitals are Lawson General at Atlanta, Ga., Vaughan General at Hines, Ill., McCloskey General at Temple, Tex., Walter Reed General at Washington, D. C., Billings General at Ft. Benjamin Harrison, Ind., Bushnell General at Brigham City, Utah, Dibble General at Menlo Park, Calif., Madigan General at Tacoma, Wash., and the U. S. Army Hospital Centers at Camp Edwards, Mass., and Camp Carson, Colo.

Lasts for orthopedic shoes will not be made until foot injuries have healed sufficiently so measurements will not change. The patient will then be sent to have a cast made at the nearest hospital which has a casting machine. Measurements can be completed within an hour. After the patient is discharged from the Army his special shoe last will be available for future use.

## "War Medicine": Vol. 7, No. 5, May 1945

This issue of *War Medicine* contains but six articles together with sixty-four abstracts from current literature and four book reviews. The abstracts are chiefly from American journals, with a few from British and Australian, and two each from Soviet and German sources.

The shortest article is probably the best and is entitled "Classification for Medical Corps Officers of the Army Air Forces" by Major William A. Glasier, MC—AUS. In it the author describes the method of classification used in the Air Forces with the objective in view "that every officer on duty with the Medical Department of the Army Air Forces shall not leave the service without having had the opportunity to maintain or better the degree of ability he originally possessed before coming on duty with the Army." Because of this system since January 1944 about one thousand Medical Corps officers have been released from the Army Air Forces to other major commands of the Army.

A group of Chicago physicians present the results of a study of the reaction of degeneration in electrodiagnosis of experimental peripheral nerve lesions. Two Navy medical officers report on "Subacute Emotional Disturbances Induced by Combat" in which they find that the ultimate source of the excitation which eventually gives rise to the syndrome described appears to lie in the failure of the elemental "fight or flight" reaction to danger and insecurity. The program of rehabilitation includes restoring the patient's self esteem and resolving some of his anxiety and promotion of his reintegration with the group.

One hundred cases of functional enuresis in the Army are studied and reported by three members of the Army of the United States. The study brings out the fact that the large majority of enuretic men examined did not have the emotional or intellectual equipment to perform satisfactory military service. Poor educational and occupational background, poor family histories and unfavorable home conditions, and various neurotic tendencies and personality disorders usually beginning in childhood were found in this group. Adequate medical attention for enuresis prior to Army service was practically lacking.

Major Clement A. Tavares, MC—ORC—USA, outlines a review of gastroscopic studies of one hundred consecutive pre-Pearl Harbor military patients from which he concludes that gastroscopic examination "is especially valuable and appears to be superior to roentgenologic procedures in the study of the large group of patients suffering from the various forms of gastritis and unexplained gross hemorrhage." He believes this diagnostic procedure should be resorted to whenever surgical procedures are contemplated.

A statistical report of one hundred Negro Army psychiatric casualties is presented by three members of the Army of the United States. Three general diagnostic categories were employed in the mental hygiene clinic where these Negroes were examined: viz., adult maladjustment, psychoneurosis and constitutional psychopathic state. Twenty-seven per cent fell into the first group, 23 per cent into the second, and 50 per cent into the third. More than one half of the total had an abnormal health history and one-fourth suffered from chronic poor health.

## "War Medicine": Vol. 7, No. 6, June 1945

Major Robert B. Lewy, MC—USA, contributes an interesting article in this issue on "Malarial Papillitis." The campaign in New Guinea has brought out the presence of persistent papillitis in patients suffering from recurrent malarial fever.

Neither quinine, quinacrine hydrochloride, nor pamaquine naphthoate were found to be a factor producing this condition. The mechanism of the process is not known and will require further study.

Two medical officers from the Royal Canadian Army Medical Corps and a Boston physician discuss "The Defects of Pemmican as an Emergency Ration for Infantry Troops," arriving at the conclusion that pemmican is undesirable as a component of military emergency rations.

Major John B. Levan, MC—AUS, describes his experiences in an Army General Hospital using simple exertional electrocardiography as an aid in the diagnosis of coronary insufficiency. Lieutenant Colonel Frederick Lemere, MC—AUS, presents a discussion of "Some Psychologic Principles of Rehabilitation." In this article he tabulates the elements of a rehabilitation program, lists the psychologic factors favoring recovery and those tending to retard it, and informs the reader how to overcome indolence. An experiment in physical reconditioning as carried out at Camp Crowder, Missouri, is outlined by Major Vernette A. Mueller, Jr., MC—AUS, and T/s Lewis K. Silverman, Detachment Medical Department, AUS. This program has been carried out with an average number of days in the reconditioning section of 21.1 for 1,444 patients. It has enabled surgeons to perform more technical and more delicate procedures and reduced the number of man hours lost to the Army from illness.

This issue contains War Department Technical Bulletins on cholera, filariasis, cutaneous diphtheria, amebiasis, and schistosomiasis japonicum. There are fifteen pages of abstracts from American, British, Australian, India and German literature of the past year, and also six book reviews. The index to Volume 7 is included.

## Promotions — Changes of Station

Everett S. Rademacher, Sr. Surg., USPHS, New Haven, is stationed at the Academy Hospital, U. S. Coast Guard Academy, New London.

Major Donald E. Tinkess, AUS, Greenwich, has been promoted to Lieut. Colonel, station unchanged.

Lieutenant Hazen A. Calhoun, USNR, Middletown, has been promoted to Captain and is serving aboard the U. S. Hospital Ship Jarritt M. Huddleston.

Colonel Ralph V. Tovell, AUS, of Hartford, formerly MDRP, Lovell General Hospital, Fort Devens, Massachusetts, has been assigned to Surgical Consultants, Professional Administrative Service.

Lieutenant George E. Roch, USN, Willimantic, a survivor from the sinking of his ship by suicide plane off Okinawa, has been home on furlough and is now reassigned to U. S. Naval Hospital, Chelsea, Massachusetts.

Lieutenant Edward V. Carvey, USNR, Wethersfield, has been assigned to the Seventh Fleet in the Philippines.

Captain Robert N. Creadick, AUS, New Haven, is assigned to China having been stationed for a time at the School of Tropical Medicine, Army Medical Center in Washington, D. C.

## Assignments of Connecticut Senators to Committees

Brien McMahon—Claims, expenditures in the Executive Departments, finance, Interstate commerce

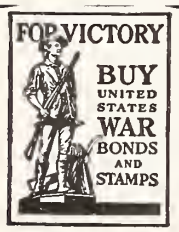
Thomas C. Hart—Civil service, commerce, manufactures, public buildings and grounds, small businesses

## Assignments of Connecticut Representative At Large to Committees

Joseph F. Ryter—Foreign affairs

## Assignments of Connecticut Representatives to Committees

1. Herman P. Kopplemann—Appropriations
2. Chase Going Woodhouse—Banking and currency
3. James P. Geelan—Coinage, weights and measures, labor, rivers and harbors, territories
4. Claire Boothe Luce—Military affairs
5. Joseph E. Talbot—Judiciary




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(SEE PAGE 2)

COMMITTEE ON PUBLIC POLICY AND LEGISLATION
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# PUBLIC AFFAIRS

## Here It Is — New Maternal and Child Welfare Bill

On July 26 Senator Claude Pepper (D., Fla.) introduced for himself and Senators David I. Walsh (D., Mass.), Elbert D. Thomas (D., Utah), Lister Hill (D., Ala.), Dennis Chavez (D., N. M.), James M. Tunnell (D., Del.), Joseph F. Guffey (D., Penn.), Robert M. La Follette, Jr., (Prog., Wisc.), George D. Aiken (R., Vt.), and Wayne Morse (R., Ore.), S. 1318, "to provide for the general welfare by enabling the states to make more adequate provision for the health and welfare of mothers and children, and for services to crippled children, and for other purposes." Following is a brief summary of the bill by sections.

I—MATERNAL AND CHILD HEALTH

Authorizes $50 million Federal Aid the first year and a sum sufficient thereafter to enable States to provide and maintain facilities and services to promote physical and mental health of mothers during the maternity period. This to include medical, nursing, dental, hospital and related services for maternity care, preventive health work, diagnostic service for children, school health services, care of sick children, correction of defects, and training of personnel to carry out these purposes. From this sum of $50 million, $5 million shall be allotted by the Secretary of Labor to the states on the basis the population under 21 years of age in each state bears to the total such U. S. population. The remaining $45 million is allotted to the states based on the factors of population of mothers and children under 21, the cost of furnishing them care, special problems of maternal and child health, and the financial need of the state in carrying out the plan.

Each state must qualfiy for the aid by providing—

1. State financial participation.
2. A state plan.
3. Service available without discrimination of race, creed, color or national origin or residence requirements.
4. State agency administrations.
5. Accepted standard of administration including personnel standards.
6. A state advisory council.

The federal aid shall be matched by state and local funds.

II—SERVICES FOR CRIPPLED CHILDREN

Authorizes $2.5 million the first year and a sum sufficient thereafter to enable each state to maintain service and facilities for care of crippled, handicapped children. This includes service for locating such children, providing medical and hospitalization care and training of personnel for such service.

$2.5 million of such sum shall be allotted by the Secretary of Labor to the states on the ratio of the population of children under 21 to the U. S. total of such population. The remaining $22.5 million to be allotted on basis of child population, cost of service, special problems, and financial need of state in carrying out the plan.

The Chief of Children's Bureau must approve state plan which must qualify the same as in I above.

The states must match the federal aid in this section.

III—CHILD WELFARE SERVICE

Authorizes $20 million the first year and thereafter a sum sufficient to assist states in developing child welfare programs, training of personnel, caring for children without parental care and supervision, or who are neglected or delinquent.

The first year, $10 million dollars of this sum is to be allotted to the states based on the ratio of child population to the total of such population and thereafter three-fourths of the total appropriation shall be so allotted. The rest of the fund shall be allotted on the basis of—

1. Child population.

2. Cost of service.
3. Special problems of child welfare.
4. Financial need of state for assistance in carrying out the plan.

To qualify, a state must agree to the same provisions as those under Section I. However, equal matching is required only of states whose per capita income is equal to or greater than the per capita income of U. S. In those whose per capita income is under the per capita income of U. S. the state contribution shall be matched to the extent required to bring the state contribution to an amount not less than 25 per cent of the total expenditures and not greater than the percentage which bears the same ratio to 50 per cent as the per capita income of the state bears to the per capita income of the U. S.

IV—CHILDREN'S BUREAU

Authorizes $5 million the first fiscal year and thereafter a sum sufficient, for necessary expenses of the Children's Bureau in administering the Act.

## Rapid Treatment Center Program of VD

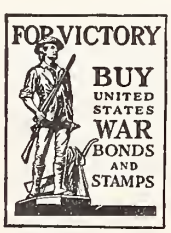
Administration of the rapid treatment center program for intensive therapy of the venereal diseases has now been assumed by the Public Health Service, under an act of Congress appropriating 5 million dollars to finance the program.

During the past 3 years the Federal Works Agency, utilizing appropriations authorized by the Lanham Act, has supplied funds to State and local health departments and other official agencies for operation and maintenance of RTC's.

The RTC's, originally conceived as a war service aid in the control of VD, were operated at first primarily to render non infectious, as quickly as possible, persons allegedly responsible for the spread of VD among the armed forces and war workers. During early days of operation it became apparent that the quick and safe treatment of the VD's afforded by in-patient care was an important contribution to the general VD control program, which ideally should be available to all persons with a venereal disease in an infectious stage. The development of treatment schedules employing penicillin for both syphilis and gonorrhea made possible even shorter periods of hospitalization than could be realized with intensive schedules of arsenic and bismuth. This development made even more apparent the benefits to the Nation as a whole which might be realized from providing in-patient care as a method in the general control program. By hospitalization it is possible to administer penicillin, a non toxic drug with high curative powers, every 3 hours day and night, to complete treatment of syphilis within a few weeks, and thus entirely eliminate the difficult caseholding problem with which public clinics long have contended.

Evolution of the program from a war facility to a general treatment facility for all patients subject to public care indicated that the program now might be administered as a responsibility of the Public Health Service in the Nationwide VD control program more properly than as a war community service financed from Lanham Act funds. The Public Health Service, therefore, was authorized to submit to the Bureau of the Budget estimates of funds necessary to continue the rapid treatment center program during the 1946 fiscal year. Congress, on July 3, appropriated 5 million dollars to be used for subsidizing the maintenance and operation of existing Federal and State centers, the payment of fees to hospitals for providing in-patient care, and the establishment of new centers as required.

Forty-four individual centers, in 35 States, including 10 Federally operated centers in 10 States, are contemplated in contract proposals received and reviewed to date. In addition, proposals for contracts with hospitals to provide beds for the intensive treatment of VD patients have been received from six States. A total of about 300 hospitals would be eligible to receive venereal disease patients under these proposals.




MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# WOMAN'S AUXILIARY

## TO THE CONNECTICUT STATE MEDICAL SOCIETY

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*First Vice-President*, Mrs. Creighton Barker, New Haven
*Second Vice-President*, Mrs. H. Bertram Lambert, *Southport*
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*Corresponding Secretary*, Mrs. Edwin R. Conners, *Bridgeport*
*Treasurer*, Mrs. Julian G. Ely, Lyme

## Fall Meeting — New Haven September 26

The Woman's Auxiliary of the Connecticut State Medical Society will meet on Wednesday, September 26, at 2:00 P. M., at the New Haven Medical Association Building, 364 Whitney Avenue, New Haven.

There will be reports on the progress of the Woman's Auxiliary and the amendments to the constitution and By-Laws will be presented.

Speakers will address the Auxiliary on Medical Legislation following which there will be a social hour and tea.

This is an important meeting and all members are urged to attend. The wives of all members of the Connecticut State Medical Society are eligible for membership and are cordially invited to become members of the Woman's Auxiliary.

Remember the date—September 26—and plan to be in New Haven.

## Board of Directors Meets

The Board of Directors of the Woman's Auxiliary of the Connecticut State Medical Society held a meeting on Wednesday, July 18, at the residence of Mrs. Robert J. Cook, 656 Whitney Avenue, New Haven. Mrs. James R. Miller, president of the State Auxiliary, presided at the meeting and reports were given by the officers and committee chairmen. At the close of the morning session the hostess, Mrs. Cook, served a very refreshing buffet luncheon.

At the afternoon session Mrs. Paul Phelps presented her committee's report on the Revision of the Constitution and By-Laws. This report which was the special business of the day was discussed at length and approved by the Board.

A get-acquainted questionnaire was also presented to the Board for approval. The questionnaire will provide a survey of the civic activities of all the members which will be a very useful preliminary to the work of the Woman's Auxiliary.

## Replies to Spring News Letter

670 Medical Clearing Co.
APO 718
6 June 45

Dear Mesdames:

It has been a distinct pleasure to receive your Spring News Letter; it is most interesting to read of the experiences had by our Connecticut colleagues. I hope to continue receiving your letter periodically.

At present, we are operating a 200-bed hospital in a beautiful city that was left absolutely undamaged by the Japs. As you undoubtedly know, it is a rare occasion when a city is left intact over here in the Philippines.

We are using a modern, well constructed hospital building. It contained all the equipment as used previously by the civilian doctors. The x-ray and fluoroscope are of the latest type, and come in for much use. The various wards are being used to great advantage. And so it goes for the entire hospital.

The grounds are beautiful, with flower gardens, hedges, gravel driveway, and palm trees. There is an adjoining chapel that was given to the hospital in 1937 by a family in Pennsylvania. It is a gorgeous building. At a later date, I may be able to send you a picture of it.

So much for now. Oh, yes! Just 2 weeks before we landed here, the Japs had planted a number of banana trees in our front lawn. The earth around the bases of the trees still showed signs of fresh digging when we arrived here.

Good luck to the continued success of your letter.

Respectfully,
Major G. L. Tunick (Greenwich)

10 June 1945
At Sea

My dear Mrs. Lambert:

I wanted to take this opportunity to thank you and the Woman's State Auxiliary of the Medical

Society for the copy of the News Bulletin that I received. It was issue No. 2, and the first one that I had seen. It is always nice to receive news from back home, and doubly nice to know to some extent what the other fellow is doing. Also it makes us feel that we are not forgotten, and out in this Pacific Ocean that is important, because we go for days and days without seeing much except water, and when we do see land, it isn't as glamorous as it has been depicted, and even if one could go ashore, there would be no place to go to when one arrived. As far as I can see the closer to Japan that we get, the worse the country is. Certainly Okinawa, which was our latest stopping off place gave us a very warm reception, but hardly the kind that I like to receive. After the first month of sleeping in my clothes there, I have anything but fond memories of the place, and will readily concede that the Army has an advantage over the Navy in that it is practically impossible to dig a foxhole in a steel deck, and one can't say that I haven't tried.

Not knowing any of the other members of the Woman's committee, and wanting to thank someone for the News, I took the liberty of writing to you. I trust that this finds you and Dr. Lambert in the best of health. Please convey my regards to the doctor.

Very sincerely yours,
Robert Nespor (Westport)

## Outlook for Women as Professional Nurses

The U. S. Department of Labor has published a sixty-one page bulletin outlining the outlook for women as professional nurses. The bulletin includes a resume of the prewar situation, a discussion of the opportunities for women with special employment problems, the post war outlook, and a tabulation of the usual minimum requirements for entrance to and graduation from a state accredited school of nursing, for membership in Cadet Nurse Corps, for licensure as a registered nurse, for application to the various civil service positions in nursing, and for entrance to the Army and Navy Nurse Corps.

Listed as Bulletin 203, Number 3, it might well serve as a source of information for all young women contemplating preparation for the profession of nursing.

## Hartford Hospital Votes to Proceed With Construction

The Hartford Hospital board has accepted the recommendations of the building and executive committees to proceed with a building program totaling $6,500,000. The program includes a new 13-story main building with the necessary furniture and equipment, an addition to the power house and a laundry and shops building, together with the necessary roads, parking areas and service connections.

The new main building will house the general administrative offices on the first floor, together with the admitting and accident departments. The second floor will be devoted to cafeterias and provisions made for the physiotherapy department and nursing arts. The third floor will be given over to laboratories and the x-ray department. The fourth floor will be devoted to operating rooms and the fifth to the twelfth inclusive to ward and semi-private rooms. The thirteenth floor will house surgical supplies and the pharmacy.

The two basement floors will contain the kitchen, large store rooms and the necessary machinery for operating the building. A tunnel system will connect all the hospital buildings, so that ready access in all weathers is provided and the movement of laundry and supplies facilitated. The entire plant will be heated from the Bell Memorial heating plant and a new electrical distribution system is being installed to replace the present outmoded wiring.

When this program is completed, Hartford will have one of the most up-to-date and efficient hospital plants in the country. The entire bed capacity of 820 beds will be housed in new buildings, together with the professional services for the care of patients, such as operating rooms, laboratories and x-ray department. The new hospital will be entered from Seymour Street and the main buildings will face an open grass court to the east, surrounded by the remaining buildings on Jefferson Street and Retreat Avenue.

The work of clearing the site will start immediately and it is hoped that the foundations may be completed before winter. A priority application was filed with WPB late last fall and it is expected that materials will be made available more or less as required. The entire program will require two years provided materials can be secured.

# STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

## Hospital, Nursing and Medical Care for Servicemen's Families Revised EMIC Program

The Emergency Maternity and Infant Care Program (EMIC) has recently been revised by the U. S. Children's Bureau to the benefit of those who take advantage of it.

Eligibility has changed somewhat under a recent Congressional recommendation to clarify the program and put it in line with the spirit of the law:

"A serviceman's wife may apply for maternity care and care for her baby, under the emergency maternity and infant care program, even after her husband has been honorably discharged, promoted, or demoted, provided she was pregnant during the period when he was in one of the four lowest pay grades of the services or was serving as an aviation cadet. On the same basis, she may apply if the husband and father is a prisoner of war, missing in action, or dead."

### ELIGIBILITY ON CHANGED STATUS DEFINED

Heretofore the application for care had to be made while the serviceman was in one of the eligible grades. Now all that is required to establish eligibility is proof that the wife was pregnant while he was in one of the eligible grades. The infant in these cases is also eligible for full care during his first year of life. Similarly, if the father of an infant whose mother did not receive care under the program was in one of those grades at any time during the infant's first year of life, the infant's eligibility for care under the program is established.

*The greatest effect of the new policy, which is retroactive to January 1945, will be in bringing infants of discharged servicemen under the program for the full year in which the infant is entitled to care.* The new regulation also clears up a matter about which some confusion has existed, that is whether widows and their infants are eligible. Under this interpretation they are without question eligible.

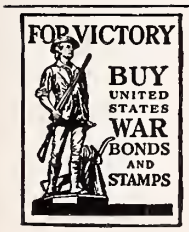
### APPLICATION PROCEDURE

The procedure to be followed in establishing eligibility is simple. The wife has only to show to her physician or other authorized person assisting her in filling out the application form an envelope or V-mail letter from her husband, her allowance card or other official communication dated at a time when he was in one of the eligible grades. If she does not have such evidence the state health department can make inquiry of the appropriate armed service.

Under the emergency maternity and infant care program, complete maternity care including medical and hospital service is provided for wives of servicemen in the eligible grades, and medical and hospital care is available for their infants through the infant's first year. Care is provided without regard to race or place of residence or financial status.

The important matter is to get care to those women and their babies, not the fine points of when the application was made. Surely all can see the justice of taking care of a man's wife and his child even though he is discharged; indeed, in many instances discharged as disabled. No argument whatsoever needs to be made for taking care of the mother and her infant in those cases where the husband and father has lost his life.

Applications in Connecticut can be obtained from the physician accepting the case, the local health officer, or the State Department of Health whose telephone number for this purpose is: Hartford 7-6341, extension 2372.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# OBITUARY

## Joseph E. Strobel, M.D.
### 1882 - 1945

Dr. Joseph E. Strobel, my associate on the staff of The Seaside since August 16, 1932, died on January 30, 1945, of a coronary infarct. He was born in Philadelphia, Penn., January 29, 1882, the son of Joseph and Margaret Strobel; received his primary and secondary education in the public schools of that city. In June 1909, he graduated from Temple University School of Medicine.

From the beginning Dr. Strobel devoted himself to the study of tuberculosis. He first served as a resident physician at White Haven Sanatorium in Pennsylvania. In April 1911 he came to Connecticut and accepted a position at Undercliff Sanatorium. In January of the following year he was transferred to Cedarcrest, where he served until the end of 1919. When Dr. Stockwell volunteered during the First World War, Dr. Strobel became superintendent, and acted in that capacity until December 31, 1919, when he resigned and entered private practice in Hartford.

On April 22, 1922 he became chief of the Tuberculosis Division of Grasslands Hospital in Westchester County, New York, where he remained until December 30, 1930. He resigned to accept an assignment with the Westchester County Department of Health as Director of its tuberculosis division. He resigned from this department on October 31, 1931 to enter private practice in Greenwich. On August 16, 1932 he returned to Connecticut to accept a position at The Seaside, which he filled until his death.

During these later years my associations with Dr. Strobel have been intimate and pleasant, and I have learned to respect his high personal and professional integrity. His knowledge of tuberculosis was profound and his opinions were respected by all his associates.

He was devoted to his family. Shortly after the birth of his only child, Mrs. Jane Buermeyer, who survived him, his first wife, Mrs. Selma Strobel, lost the power of her lower limbs as the result of a spinal cord tumor, and remained an invalid until her death. All through her 19 years of illness he was a most devoted husband and father.

In April 1937 Dr. Strobel married as his second wife Margaret Rose, at that time a nurse in the Bureau for the After Care of the Tuberculous of Westchester County. His second marriage was very happy, and he was able to devote himself more closely to his profession.

He had two hobbies that gave him a great deal of pleasure. One was the raising of tropical fish, and the other was the breeding of pedigreed canaries. In both he was very successful.

Dr. Strobel was a Master Mason, member of Pythagoras Chapter No. 88, and a member of Christ Episcopal Church, Greenwich.

John F. O'Brien, M.D.

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## Health Insurance Problems In U. S. Given Scientific Study

Compulsory health insurance with all its broad ramifications is reviewed in the July 21 issue of *The Journal of the American Medical Association* which says, editorially, that it "is offered as a report of a scientific investigation into the forces now promoting the mechanism for medical service incorporated in the Wagner-Murray-Dingell bill."

*The Journal's* article, prepared by Carl W. Strow and Gerhard Hirschfeld, research consultant and director, respectively, of the Research Council for Economic Security, sheds light on various national health problems in order that a better view might be obtained on the subject of compulsory health insurance.

The researchers' conclusions are pertinent:

"The demand for compulsory health insurance is promoted most powerfully by organized collective action, especially by organized labor. . . . Apparently, the opportunity to organize the demand is more important than the prevalence of the need for medical care. The evidence points to the probability that, contrary to popular belief, the legislative proposals for compulsory health insurance are based not so much on social needs as on political interests, and that the ability on the part of labor to organize and press the demand, rather than the concern about the state of health, is the primary consideration. . . .

"Illness apparently is not chiefly responsible for the demand for compulsory health insurance. If it were, recommendations would start in the medically least progressive states. However, they originate at the opposite end of the scale, where medical care and social services are most highly developed."

# CONNECTICUT CANCER SOCIETY CHANGES BY-LAWS AT ANNUAL MEETING

Edwin R. Meiss, *Managing Director*

The requirement that a majority of the trustees of Connecticut Cancer Society must be members of the Committee on Tumor Study of the Connecticut State Medical Society was dropped from the by-laws at the annual meeting of the Society on June 21, 1945. The meeting, held at the Medical Association Building in New Haven, was attended by Rear Admiral Charles S. Stephenson, new managing director of the American Cancer Society, and other officers of the national organization, as well as citizens from all sections of the state.

Members of the Committee on Tumor Study who had served as trustees were re-elected to that office as individuals, but by voting for the changed by-laws they ended the official position of the Committee on the Board of Trustees. Instead, the Cancer Society will have a Medical Advisory Committee of seven members, nominated each year by the Committee on Tumor Study, to initiate or consider all proposals for the use of the Society's funds for medical purposes. Educational activities will be supervised by a Public Education Committee of five members, while a Finance Committee of five business men will supervise the management of the Society's funds.

The new by-laws were considered by the Committee on Tumor Study at its own June meeting and several revisions suggested. These were proposed at the Annual Meeting of the Cancer Society by Dr. Hugh M. Wilson, chairman of the Committee on Tumor Study and a member of the Society's Executive Committee. The two principal revisions provided that the president of the Society and at least one member of the Public Education Committee shall be members of the Connecticut State Medical Society. With these amendments the new by-laws were adopted.

Dr. A. N. Creadick, president of the Society, then called a meeting of the Incorporators. Amended Articles of Association required by the growth of the Society were presented. With certain clarifications suggested by Dr. James R. Miller, the amended articles were adopted.

Dr. Creighton Barker reported for the nominating committee. He pointed out that it was the intention of the Society, as indicated in its new articles and by-laws, to enlarge the Board of Trustees, and that various prominent citizens, Field Army chairmen and campaign chairmen had been included. It was unanimously voted to cast one ballot for the entire slate. Among those elected or re-elected trustees were: Creighton Barker, M.D.; Richard I. Barstow, M.D.; Eugene C. Beck, M.D.; John D. Booth, M.D.; Donald A. Bristoll, M.D.; W. W. Bunnell, M.D.; Joseph O. Collins, M.D.; Howard Colwell, M.D.; Thomas J. Danaher, M.D.; Edward J. Foster, M.D.; Charles W. Gaylord, M.D.; Crawford Griswold, M.D.; M. H. Griswold, M.D.; Carl C. Harvey, M.D.; Louis P. Hastings, M.D.; Victor Heiser, M.D.; Ira V. Hiscock, SC.D.; Joseph Howard, M.D.; Russell A. Keddy, M.D.; Ralph E. Kendall, M.D.; Kenneth K. Kinney, M.D.; Louise D. Larimore, M.D.; Edwin A. Lawrence, M.D.; Wendelin G. Luckner, M.D.; John A. McCreery, M.D.; William Mendelsohn, M.D.; James R. Miller, M.D.; D. C. Y. Moore, M.D.; Peter A. Nestos, M.D.; Ralph T. Ogden, M.D.; Stanley H. Osborn, M.D.; Berkley M. Parmelee, M.D.; Douglas J. Roberts, M.D.; George M. Smith, M.D.; Harry J. Wieler, M.D.; Hugh M. Wilson, M.D.; C. E. A. Winslow, DR.P.H., and M. C. Winternitz, M.D. The meeting of Incorporators was then adjourned, and the president welcomed and called to order the new trustees.

The actions of the Executive Committee since the previous annual meeting, as reported by Dr. Barker, were approved. Dr. Barker then took the chair while Dr. Creadick presented the annual report of the president. After a review of the Society's activities, Dr. Creadick expressed his belief that, in spite of the complexity of the problems presented by cancer, progress has been made in early detection and treatment.

"Tremendous avenues of study which have not yet been completed must be continued and supported," he said. "Meanwhile, our duties are clear: (1) a certain percentage of the funds we have raised must return to the districts in order to assist local social agencies and field armies in providing care to indigent patients in small personal ways that are not yet covered by public funds. (2) Secretarial assistance, equipment and facilities for the improvement of the several tumor clinics are required. It is not our province to discuss how pay or part-pay patients should be handled—that matter must be left

to the local medical officers. It is not fair for us to arouse lay people and then not assist in supporting agencies to meet their needs. (3) It is perfectly legitimate that we support any measures for the better training of the medical men who staff the clinics. (4) It is of paramount importance that we continue educating and advising the laity. (5) We stand in a public position—partly lay, partly professional—so that we may be able to provide means of interpreting lay complaints to the medical profession and, at the same time, improve the public relations of the profession by interpreting the accomplishments and limitations of the medical men to the public. (6) The portion of our funds which goes to the National Society is now being administered in the field of research so that worthy projects in our own state and elsewhere many receive grants-in-aid."

Rear Admiral Stephenson outlined plans for a vigorous national program of research financed by the Society and supervised by the National Research Council, an independent body of scientists. Dr. Joseph Howard, president of the Connecticut State Medical Society, extended his good wishes to the Society for the coming year.

Officers' reports were presented by Mrs. Douglass O. Burnham, state chairman of the Field Army; Charles F. Lewis, treasurer; Edwin R. Meiss, managing director; Miss Mollie Cullen, state publicity chairman; Daniel Finn, campaign publicity chairman; and Edwin J. MacEwan, State campaign vice-chairman.

The president then called for the election of officers.

Dr. Barker again presented the report of the nominating committee. The following officers and committee members were unanimously elected:

*President:* A. N. Creadick, M.D.
*Vice-President:* Ira V. Hiscock, C.P.H., SC.D.
*Secretary:* Joseph O. Collins, M.D.
*Treasurer:* Charles F. Lewis
*Chairman of the Field Army:* Mrs. Douglass O. Burnham
*State Campaign Chairman:* Edwin J. MacEwan
*Managing Director:* Edwin R. Meiss

*Executive Committee*

Dr. A. N. Creadick, Chmn.
Mrs. D. O. Burnham
Ira V. Hiscock
Dr. Stanley H. Osborn
Dr. Hugh M. Wilson
Dr. Creighton Barker
Chmn., Finance Committee
Chmn., Med. Advisory Committee
Campaign Chairman

*Public Education Committee*

Mrs. D. O. Burnham
Dr. A. L. Burgdorf
Dr. Alonzo Grace
Dr. Douglas Roberts
Eleanor MacDonald

*Finance Committee*

James W. Cooper, Chmn.
Morgan Brainard
L. L. Hemingway
Edward N. Allen
James Lowell

*Publicity Committee*

Mollie Cullen
Daniel Finn
Russell Sumpf
Emily Monley

On motion of Dr. Louis P. Hastings of Hartford, the Trustees authorized the Executive Committee to study and take action on the proper organization of local branches and their integration into the state organization.

When the business session adjourned refreshments were served by the ladies of the Society's New Haven Field Army, Mrs. George M. Hodson, chairman.

Since the annual meeting, the Committee on Tumor Study of the State Medical Society has announced its appointments to the Medical Advisory Committee of the Connecticut Cancer Society as follows:

Alfred L. Burgdorf, Chairman, Hartford
Wilmar M. Allen, Hartford
Howard S. Colwell, New Haven
William U. Gardner, New Haven
Joseph I. Linde, New Haven
George M. Smith, Pine Orchard
Donald B. Wells, Hartford

## ARTICLES OF ASSOCIATION OF CONNECTICUT CANCER SOCIETY, INC.

### Branch of American Cancer Society, Inc.

As adopted June 21, 1945

Be it known that we, the subscribers, do hereby associate ourselves as a body politic and corporate pursuant to the statute laws of the State of Connecticut regulating the formation and organization of corporations without capital stock, and the following are our Articles of Association:

ARTICLE 1. The name of said corporation shall be CONNECTICUT CANCER SOCIETY, INC., Branch of American Cancer Society, Inc.

ARTICLE 2. The purposes for which said corporation is formed are the following, to wit:

To coordinate the activities of the Society within the State of Connecticut with similar activities being carried on by the Connecticut State Medical Society and the Connecticut State Department of Health.

To aid voluntarily in cooperation with accredited physicians, indigent cancer patients in securing adequate diagnosis or treatment, to assist voluntarily in the establishment, development, equipment or maintenance of hospitals, clinics, laboratories or other facilities for the care of cancer patients; generally to carry on any other activities which may contribute toward the control of cancer; and to perform any other duties which may be designated by the Board of Trustees, except the actual treatment of cancer patients or the actual operation of hospitals, clinics, laboratories or other facilities for such treatment, and to organize and administer

the Field Army, an organization of volunteer workers for the aforesaid purposes.

Article 3. The said corporation is located in the City of Waterbury, County of New Haven, State of Connecticut, and the location of the principal office is at 95 North Main Street.

Article 4. The affairs of said corporation shall be managed by a Board of not less than twenty (20) Trustees, who shall elect such committees as they may desire and shall also elect a President, Vice-President, Secretary, a Chairman of the Field Army, a Treasurer, and such other officers as the Board may designate.

Article 5. Every subscriber to these Articles agrees to abide by the rules and by-laws that may be adopted by this corporation and to conform to the requirements of the statutes of the State of Connecticut governing such organizations.

Article 6. The number of incorporators shall be not less than ten (10), and any vacancies occurring in said number shall be filled at the annual meeting of the corporation by a majority vote of those present, and additional incorporators may be elected in like manner.

Article 7. The name of the agent upon whom process may be served is Dr. Creighton Barker, 258 Church Street, New Haven, Connecticut.

Dated at Waterbury, this 21st day of June, 1945.

## BY-LAWS OF CONNECTICUT CANCER SOCIETY, INC.

### Branch of American Cancer Society, Inc.

As adopted June 21, 1945

### ARTICLE I—INCORPORATORS

Section 1. The Annual Meeting of the Incorporators shall be held during the third week in June each year.

Sec. 2. Special meetings of the Incorporators shall be held upon the call of the President, and in the event that the President refuses or is unable to act, upon the call of three or more Incorporators.

Sec. 3. The number of Incorporators may be changed from time to time as the Incorporators may desire.

Sec. 4. At all meetings of the Incorporators, seven shall constitute a quorum.

Sec. 5. A written or printed notice of every meeting of the Incorporators, stating the day, hour and place thereof, shall be given by the President or Secretary to each Incorporator by leaving such notice with him or at his residence or usual place of business, or by mailing a copy thereof to him at his last known Post Office address at least five days before said meeting.

### ARTICLE II—MEETINGS OF TRUSTEES

Section 1. The Annual Meeting of the Trustees shall be held immediately following the Annual Meeting of the Incorporators and notice of this meeting shall be given in the same manner as required for the Incorporators.

Sec. 2. Special meetings of the Trustees may be called by the President, and in the event of his refusal or inability to act, by three or more trustees.

### ARTICLE III—BOARD OF TRUSTEES

Section 1. The Board of Trustees, consisting of not less than twenty trustees, shall manage and conduct the property and business of the corporation. The Incorporators may from time to time by appropriate vote increase the number of trustees. The Board of Trustees shall be constituted of the following: the President of the Corporation, the Governor of the State of Connecticut, the Commissioner of Health and the Commissioner of Education for the State of Connecticut, the President and the Executive Secretary of the Connecticut State Medical Society, the Chairman of the Committee on Tumor Study of the Connecticut State Medical Society, the Chairman of the Association of Connecticut Tumor Clinics, the Chief of the Division of Cancer Research of the State Department of Health, the State Chairman of the Field Army, the Chairmen of the Finance, Medical Advisory, Public Education, Campaign, and Publicity Committees, and such other individuals as the Incorporators may elect, provided however that at least ten of the trustees shall be members of the Connecticut State Medical Society. The Trustees shall be elected at the annual meeting of the Incorporators, and shall continue in office for one year and until their successors shall be chosen and qualified. The Board of Trustees shall have the power to fill all vacancies among its members, choosing a person as trustee to fill the unexpired term.

Sec. 2. At the annual meeting held immediately after the annual meeting of the Incorporators or at any meeting of the Trustees held in lieu of such stated meeting, the Board of Trustees shall elect a President, a Vice-President, Secretary, a Treasurer, a Chairman of the Field Army, and the Board may appoint such other officers from time to time as may be for the best interests of the corporation. Any officer or agent chosen or appointed by the Board of Trustees shall be removable at the pleasure of the Board of Trustees, and any vacancy in any office may be filled by the Board of Trustees.

Sec. 3. At all meetings of the Trustees seven members shall constitute a quorum.

### ARTICLE IV—EXECUTIVE COMMITTEE

Section 1. The Board of Trustees shall appoint from their number an Executive Committee constituted of not less than five nor more than eleven members of the Trustees, including the President, who by virtue of his office shall be Chairman, and the Chairman of the Field Army, for the transaction of such business of the corporation as may require their attention between the meetings of the Board of Trustees; and all business transacted by this committee shall be submitted to and be approved by the Board of Trustees at their next regular meeting, if required. The members of the Executive Committee shall serve for one year or until the election of their successors. The Executive Committee shall appoint and prescribe the duties of a Managing Director and fix his compensation and term of employment. It shall appoint and prescribe the duties of the Campaign and Publicity Chairmen, and the chairmen of such other committees as may be considered advisable. The Executive Committee shall also supervise the activities of the corporation and the work of the Managing Director and the other representatives and employees of the corporation, and shall prepare the annual budget for submission to the Finance Committee.

Except as otherwise provided by the By-Laws, or by resolution of the Board of Trustees, all salaries and compensation paid or payable by the corporation shall be fixed by the Executive Committee. Further, the Executive Committee shall supervise and approve the financial activities of the corporation.

Sec. 2. The Executive Committee shall fix its own rules of proceeding, and shall meet where and as provided by such rules, but in every case the presence of at least five members shall be necessary to constitute a quorum.

Sec. 3. The Executive Committee shall have a regular meeting once each month, at a time and place to be agreed upon.

## ARTICLE V—FINANCE COMMITTEE

Section 1. The Executive Committee shall nominate a Finance Committee consisting of a chairman and four other members for election by the Board of Trustees for a term of one year. The Executive Committee shall keep the membership of such committee at five members, and shall have the power to fill all vacancies.

Sec. 2. The Finance Committee shall fix its own rules of proceeding, and shall meet where and as provided by such rules, but in every case the presence of at least three members shall be necessary to constitute a quorum.

Sec. 3. The Finance Committee shall supervise the investment of funds of the corporation. It shall consider and submit to the Board of Trustees with its recommendations the Annual Budget prepared by the Executive Committee. It shall pass on all applications referred to it by the Executive Committee for expenditures from the Contingency Fund. All actions of the Finance Committee shall be reported to the Executive Committee at its meeting next succeeding such action and shall be subject to the approval of the Executive Committee.

## ARTICLE VI—MEDICAL ADVISORY COMMITTEE

Section 1. The Committee on Tumor Study of the Connecticut State Medical Society shall nominate a Medical Advisory Committee consisting of a chairman and six other members for election by the Board of Trustees for a term of one year. The Committee on Tumor Study shall keep the membership of this committee at seven members, and shall have the power to fill all vacancies.

Sec. 2. The Medical Advisory Committee shall fix its own rules of proceeding, shall meet when and as provided in such rules, but in every case the presence of at least three members shall be necessary to constitute a quorum.

Sec. 3. The Medical Advisory Committee shall consider or initiate all proposals dealing with the scientific and medical phases of the corporation's program except public education. It shall forward to the Executive Committee recommendations for disbursement of the corporation's funds for scientific and medical phases of the program. All actions of the Medical Advisory Committee shall be reported to the Executive Committee at its meeting next succeeding such action, and shall be subject to the approval of the Executive Committee.

## ARTICLE VII—PUBLIC EDUCATION COMMITTEE

Section 1. The Executive Committee shall nominate a Public Education Committee consisting of a chairman and four other members for election by the Board of Trustees for a term of one year. At least one member shall be a member of the committee on Tumor Study of the Connecticut State Medical Society. The Chairman of the Field Army shall be a member of this committee. The Executive Committee shall keep the membership of such committee at five members, and shall have the power to fill all vacancies.

Sec. 2. The Public Education Committee shall fix its own rules of proceeding, shall meet when and as provided in such rules, but in every case the presence of at least three members shall be necessary to constitute a quorum.

Sec. 3. The Public Education Committee shall consider or initiate all proposals dealing with the public educational phases of the corporation's program. It shall forward to the Executive Committee recommendations for disbursement of the corporation's funds for public education purposes. All actions of the Public Education Committee shall be reported to the Executive Committee at its meeting next succeeding such action, and shall be subject to the approval of the Executive Committee.

## ARTICLE VIII—DUTIES OF OFFICERS

Sec. 1. *President:* The President shall be the chief executive officer of the corporation. He shall be a member of the Connecticut State Medical Society. He shall preside at all meetings of the Incorporators, Trustees, and the Executive Committee; he shall have general and active management of the business of the corporation; he shall see that all orders and resolutions of the Incorporators, Board of Trustees, and Executive Committee are executed, subject, however, to the right of the Board of Trustees to delegate any specific powers, except such as may be by law exclusively conferred on the President, to any other officer or officers of the corporation. When authorized by the Board of Trustees or Executive Committee he shall execute contracts, bonds, mortgages, releases of mortgages and other instruments, and affix the seal to any instrument requiring the same.

Sec. 2. *Vice-President:* The Vice-President, in the absence or disability of the President, shall perform the duties and exercise the powers of the president, and shall perform such other duties as shall be from time to time imposed upon him by the Board of Trustees.

Sec. 3. *Secretary:* The Secretary shall record all votes and minutes of all proceedings in a book to be kept by him for that purpose, and he shall perform like duties for all standing committees when required. He shall keep in safe custody the seal of the corporation. He shall give or cause to be given notice of all meetings of the Incorporators, Board of Trustees, and Executive Committee and shall perform such other duties as may be prescribed by the Executive Committee.

Sec. 4. *Treasurer:* The Treasurer shall have the custody of the corporate funds and securities and shall keep full and accurate accounts of receipts and disbursements in books belonging to the corporation, and shall deposit moneys and other valuable effects in the name and to the credit of the corporation in such depositories as may be designated by the Board of Trustees or the Executive Committee. The Treasurer shall, with the written approval of not less than a quorum of the Board of Trustees or a majority of the Executive Committee, place all of its corporate funds and

securities in the custody of any bank or trust company engaged in business in the state of Connecticut, and employ such bank or trust company to perform the bookkeeping, supervisory, clerical or other work, including the collection of such income from said funds and securities involved in the management and care thereof, and agree to pay such bank or trust company for such services a fee approved by a quorum of the Board of Trustees, or a majority of the Executive Committee. The Treasurer shall disburse such funds of the corporation as may be legally ordered by the Board of Trustees or Executive Committee, taking proper vouchers for such disbursements, and shall render to the Incorporators, Board of Trustees, Executive Committee, Finance Committee, or President, whenever requested, an account of his transactions as Treasurer and of the general condition of the corporation. The Managing Director or such other individual as the Executive Committee may authorize shall counter-sign all checks drawn by the Treasurer on the corporation's funds. The Treasurer shall give the corporation a bond if required by the Board of Trustees or Executive Committee in a sum and with one or more sureties satisfactory to the Board of Trustees or Executive Committee for the faithful performance of the duties of his office and for the restoration to the corporation in case of his death, resignation or removal from office of all books, papers, vouchers, money and other property of whatever kind in his possession and under his control belonging to the corporation.

Sec. 5. *Chairman of the Field Army:* The Chairman of the Field Army shall be the executive officer of the corporation in charge of the volunteer workers comprising the Field Army. The Chairman of the Field Army shall preside at all meetings of the Field Army, shall direct the activities of the Field Army in carrying out the corporation's program of public education and service, and shall seek to organize branches of the Field Army in all districts of the state, subject to the approval of the Executive Committee.

Sec. 6. *Managing Director:* Among the duties prescribed for the Managing Director by the Executive Committee, he shall attend all meetings of the Incorporators, Board of Trustees and Executive Committee and act as clerk thereof.

ARTICLE IX—GENERAL

Sec. 1. *Fiscal Year:* The fiscal year of the corporation shall begin on the first day of July in each year and end on the following 30th day of June.

Sec. 2. *Local Branches:* The Executive Committee and the Public Education Committee shall organize local branches throughout the State. The appointment of the chairman and president of each local branch shall be subject to the approval of the Executive Committee.

Sec. 3. All funds collected in the name of the corporation shall be deposited with the State Treasurer of the Corporation.

Sec. 4. *Seal:* The seal of the corporation shall be circular in form with the words "Connecticut Cancer Society, Inc." on the circumference and the word "seal" in the center.

Sec. 5. *Order of Business:* At all regular meetings of the members of the corporation, of the Board of Trustees and of the Executive Committee, the regular order of business shall be as follows:

1. Roll Call.
2. Reading of Minutes.
3. Reports of Officers.
4. Reports of Regular and Special Committees.
5. Report of Managing Director.
6. Reports of other representatives of the corporation.
7. Unfinished Business.
8. New Business.

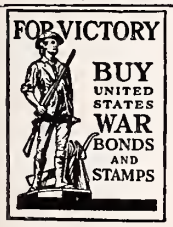
Sec. 6. Within ten days after each meeting of all Standing Committees, a copy of its minutes shall be forwarded to the Secretary, President, and the Managing Director.

ARTICLE X—AMENDMENTS TO BY-LAWS

Sec. 1. These by-laws may be altered or amended at any meeting of the Trustees, whether annual or special, by a majority vote of the trustees present, provided that in the call for such meeting notice of the intention to amend the by-laws shall have been given.

## Treat Vincent's Angina by Dissolving Sulfathiazole Tablet On the Tongue

By treating Vincent's angina (an infectious, mildly contagious disease affecting the membranes of the mouth) with a sulfathiazole tablet dissolved on the tongue every two hours during the day and two such tablets dissolved in such manner every four hours at night, the treatment time on the average case has been cut from ten days to seventy-two hours, Lieutenant Commander William W. Manson, MC—USNR, and Lieutenant Commander Irwin T. Craig, MC—USNR, declare in *The Journal of the American Medical Association* for February 3 in reporting on the results they obtained in 48 cases of this disease. In all of the cases reported by them, the infection was confined to the tonsils.




**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)

# SPECIAL NOTICES

## ORIENTATION COURSE IN CLINICAL ALLERGY

The School of Medicine, University of Pittsburgh, offers an Orientation Course in Clinical Allergy, under the sponsorship of The American Academy of Allergy, for five days, October 1 to 5, 1945, inclusive, at the School on Bayard Street, Pittsburgh, Pennsylvania. Fee $40.00; for veterans, service men, and residents $10.00. Registration for evening round table conferences only by special arrangements.

Inquiries should be addressed to William S. McEllroy, M. D., Dean, School of Medicine, University of Pittsburgh, Pittsburgh 13, Pennsylvania.

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Columbia University
in
The City of New York
Faculty of Medicine
Announces

## POSTGRADUATE COURSES IN CLINICAL MEDICINE

at

The Mount Sinai Hospital

Fifth Avenue at 100th Street, New York 29, N. Y.

Beginning Week of OCTOBER 22, 1945

Allergy; *Anesthesia; Cardiovascular Diseases; Chemistry; Diseases of the Chest, (Advanced Course); Diagnosis and Therapy; Electrocardiography (Intensive Clinical); Gastroenterology; Gastroscopy; Geriatrics (Disease in the Aged); Hematology (Laboratory Course); Diseases of Kidneys and Arteries; Diseases of Liver and Biliary Passages; General Medicine; Neurology: Electroencephalography, Neuroanatomy, Neuropathology; *Ophthalmology; Orthopedics; *Otology; Pathology (General and Special); Pediatrics; Pharmacology; Physical Therapy; Physiology of Digestive Tract; Proctology, Medical and Diseases of Colon; *Surgery of Gastrointestinal Tract; *X-Ray of Heart and Great Vessels (Intensive Course).

Endocrinology and Metabolism (December 17-22, 1945).

Recent advances in Gynecology (November 12-17, 1945).

*Open to specialists, only.

Applications should be submitted prior to October 8, 1945.

For further information, address the Secretary for Medical Instruction, The Mount Sinai Hospital, Fifth Avenue at 100th Street, New York 29, New York.

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## MEDICAL BOOKS WANTED

The Medical and Surgical Relief Committee of America has received an appeal for medical books from Dr. Severinghaus, member of the Medical Nutrition Mission in Italy. The Mission has set up in a hospital called the Polyclinica which is part of the University of Naples. The books are for the use of the Mission. Later it is intended to donate them to the Pediatric Clinic library.

The list of books requested is as follows:

1. R. P. Strong: Stitt's Diagnosis, Prevention, and treatment of Tropical Diseases—Seventh edition. 2 volumes. Blakiston.
2. Conant, Martin, et al.: Manual of Clinical Mycology. Saunders.
3. Saxl: Pediatric Dietetics. 1937. Lea and Febiger.
4. Brennerman's loose leaf Pediatrics. Nelson, 4 volumes.
5. Best and Taylor: Physiological Basis of Medical Practice. Williams and Wilkins.
6. McLester: Clinical Nutrition and Dietotherapy. Saunders.
7. Miller: Oral Diagnosis. Blakiston.
8. Peters and Van Slyke: Quantitative Clinical Chemistry. Williams and Wilkins. 2 volumes.

As a result of the war and German occupation, the European scientific world is at a tremendous disadvantage, not only because such an appallingly large amount of equipment has been destroyed or stolen, but also because it has been impossible for professional men to continue their normal pursuits of research, teaching, writing or studying. Progress in any direction has been impossible. Therefore, whatever Americans can do to help scientific knowledge in France, Italy and other countries to reach and keep abreast of the level attained in the United States, will be of inestimable value. It is for these reasons that an appeal is being made to American physicians.

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## Board of Ophthalmology Changes Date

Due to transportation difficulties the examination of the Board, originally scheduled for Chicago, October, 1945, has been postponed to January 18th to 22nd inclusive, 1946.

1946 Examinations: Chicago, January 18th thru 22nd. Los Angeles, January 28th thru Feb. 1st. New York, May or June. Chicago, October.

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## $34,000 In War Bonds As Prizes

for the best art works by physicians, memorializing the medical profession's "Courage and Devotion Beyond the Call of Duty" (in war and in peace).

This prize contest is open to any physician member of the American Physicians Art Association, including medical officers in the armed forces of the United States and Canada.

Full information available on request of the sponsor, Dr. Francis H. Redewill, Flood Bldg., San Francisco, Cal., or Mead Johnson & Co., Evansville, Ind., U.S.A.

# There are two funny things about Wilmer



**The first** is Wilmer's getup.

**The second** is that he doesn't care if he *does* look like a castoff scarecrow.

Because Wilmer's a lot smarter than he looks. While he's making more than he's ever made before, the dough he'd spend for a fancy wardrobe goes right smack into War Bonds . . . and for this Uncle Sam is mighty proud of him.

Naturally, you don't have to look like Wilmer . . . or tramp around in rags . . . to make your country proud of you, and your own future a whole lot more secure.

**All you have to do** is keep getting those War Bonds—and then forgetting them till they come due. Not bad—that four dollars for every three, and the safest investment in the world!

Why not get an *extra* War Bond today?

**BUY ALL THE BONDS YOU CAN...**
**KEEP ALL THE BONDS YOU BUY**

# CORRESPONDENCE

## Laxity in Dispensing Narcotic Drugs

STATE OF CONNECTICUT
DEPARTMENT OF HEALTH
HARTFORD 6

August 3, 1945

To the Editor:

I am enclosing herewith a copy of a memorandum from Commissioner Anslinger to district supervisors, together with a copy of the report of the Federal Grand Jury in Oklahoma, which he suggests might be printed in the state pharmacy journals. Mr. Rivard is taking a copy of this material to the editor of the state pharmacy journal and I presume it will be published. It occurs to me that you might like to consider printing this material in the State Medical Journal as well.

I can appreciate the position of the pharmacists who do not wish to turn down a request by a physician but I can also appreciate difficulties that might be encountered if prescriptions are not written according to law. I will leave to your judgment the publicity you wish to give to this material.

Sincerely yours,
Millard Knowlton, Director,
Bureau of Preventable Diseases

TREASURY DEPARTMENT
BUREAU OF NARCOTICS
WASHINGTON 25

July 23, 1945

MEMORANDUM FOR DISTRICT SUPERVISORS

I enclose a copy of the report of the Federal grand jury at Muskogee, Oklahoma, dated June 26, 1945, relating to the dispensing of narcotic drugs pursuant to telephone orders of physicians, and suggest that you arrange to have this report printed in the state pharmacy journals in your district.

/s/ H. J. ANSLINGER,
Commissioner of Narcotics

REPORT OF THE FEDERAL GRAND JURY AT MUSKOGEE, OKLAHOMA, DATED JUNE 26, 1945

"We also beg to report that we have made a partial investigation of a report concerning laxity in the dispensing of narcotics by some of the medical profession and some of the druggists. The facts developed disclosed a rather shocking disregard of the law. In some instances it appears now that some druggists fill telephone prescriptions for narcotics and later take the prescriptions to the doctor for his signature. It also appears now that an unnecessarily large quantity of narcotics is being dispensed by some druggists and physicians to persons who are well known addicts. The investigation thus far reveals an astounding condition in this respect. We do not wish to place ourselves in a position or attempt to determine when or under what manner, or in what quantities a person may need narcotics for the alleviation of pain or suffering, but we feel that we are in position to say that the conditions above referred to are intolerable and wholly unwarranted, and if continued can only result in an indictment wherever warranted. It has been stated in defense of this condition that the doctors are overworked and prescriptions by telephone are time savers. We are conscious of the overworked condition of most of our physicians, but we disagree with the contention that such practice is warranted in order to save time. It is a matter of obeying or violating the law.

"We are making this report at this time in the hope that these abuses, as well as any others not mentioned herein, may be speedily corrected. We propose to pursue this investigation further when next called and will then take such action as the facts and circumstances warrant at that time."

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## Removing Blood Clot in Tonsillectomy

To the Editor:

During these days of first-aid training it might be well to mention a procedure which could be a life saver in an emergency.

In the routine operation of tonsils and adenoids, even when suction is used, a certain amount of blood may trickle down into the trachea and bronchi. This condition is easily recognized by the bubbling breathing sounds of the patient. Although the blood clot is usually coughed up as the patient reacts from the anesthesia, it is best to get it out immediately, that is before the patient leaves the operating table.

If the patient is a child and not too heavy to lift, this can be done quickly and easily by the following method. While the patient is lying on his back on the table, and you are standing on his right side, facing him, reach across his abdomen and get a firm hold on his left wrist with your right hand. Then roll him under and into the bend of your




# GUARANTEE OF

# PURITY, QUALITY, WHOLESOMENESS

The Sealtest System of Laboratory Protection was organized to protect the public. Ice cream, milk and dairy companies which display the red-and-white Sealtest Seal are pledged to maintain high standards of *purity, quality and wholesomeness.*

That these standards are becoming more and more rigid is assured through constant examination and testing by hundreds of chemists in more than 100 chemical and bacteriological laboratories.

## The **SEALTEST** Ice Creams of Connecticut

Fro-joy Ice Cream ★ Sagal Lou Ice Cream

Manchester Dairy Ice Cream

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right arm and balance him on your right hip. Place the palm of your left hand over his forehead from his under side and step out clear of the table and other equipment. Next, lower his head slightly and spin around to your right. The centrifugal motion will throw the clot out. In the event this emergency arises with an adult or heavy patient, he can at least be draped over the table or side of the bed with head down. A gentle shake up and down will help dislodge the clot.

Immediately the clear breathing sounds can be noticed. Color and circulation are improved. Thereby the incidence of lung abscess may be reduced. The same procedure could be practiced for other foreign bodies in the larynx, mucous plugs in new born babies and vomitus cases.

William H. Turnley, M.D., Stamford

## Prepaid Medical Service Plans in Other States

MISSOURI

Word comes from Dr. Carl F. Vohs, its president, that Missouri Medical Service was launched March 12 and that sixty per cent of the St. Louis doctors and forty per cent of those in the State have signed participating contracts. The Blue Cross and the Missouri Medical Service maintain separate organizations but enrollment of plan is through the Blue Cross thereby affecting many economies Dr. Vohs reports.

WASHINGTON STATE

Washington State has seventeen medical and hospital service plans serving seventeen different communities, all conducted under the direction and with the approval of local medical societies. These plans are bound together in a somewhat loose federation. The medical service idea in Washington State started in Pierce County back in 1917. "First and foremost in the minds of the doctors were the fundamental principles of the practice of medicine, namely that the patient should have his free choice of doctors; that all doctors have the right to participate in the program on a fee for service basis; that there should be no third party interference between doctor and patient."

MICHIGAN

Increase of benefits to subscribers with no increase in rates has been announced by Michigan Medical Service—nearly 800,000 persons are entitled to new benefits.

# OUR NEIGHBORS

## Massachusetts

Reginald Fitz, Brookline, is the president of the Massachusetts Medical Society for 1945-1946 and Dwight O'Hara, Waltham, the president-elect.

## New York

Group Health Cooperative, 70 Wall Street, has announced that, through the cooperation of the Visiting Nurse Service of New York, the Visiting Nurse Association of Brooklyn and the Visiting Nurses Association of Staten Island, it will provide visiting nurse service for subscribers to its medical care insurance plan at no increase in premiums. This is the first time that visiting nurse service has been included in a voluntary health insurance plan.

Subscribers will be entitled to the amount of service their doctors consider necessary in any illness covered by the medical plan. The Group Health plan provides insurance against doctors' bills in any hospitalized illness as well as for doctors' services for any surgical care rendered in the home or doctor's office. The plan also covers maternity care.

## Rhode Island

The Rhode Island Public Expenditure Council has published data showing the shift of responsibility for public health programs to state and federal governments. Of the thirty-nine cities and towns in Rhode Island in 1943, only eight spent more than $2,000 for health. Of the remaining thirty-one communities, six spent nothing, twelve spent less than $100, and twenty-one spent less than $500. During the same fiscal year there were but three towns that spent less than $1,000 for welfare, three that spent less than $1,000 for public safety, four that spent less than $5,000 for public works, and none that spent less than $10,000 for education.

Effective July 1, 1945, Rhode Island has new regulations relative to lights and lighting equipment on automobiles. These regulations pertain particularly to the use of spot lights and fog lamps. Under the classification of authorized emergency vehicles, physicians' automobiles may carry spotlights provided they make written application to the Registrar of Motor Vehicles.

On June 6, 1945 the Pawtucket Medical Society celebrated its fiftieth anniversary at the Pawtucket Golf Club.




To the pregnant woman many days seem twice as long as they really are. In spite of precautions, vitamin deficiency induced by fetal needs, unbalanced diet, increased metabolism, and faulty absorption may be added to her other burdens. During this period of many worries, Upjohn vitamins, small and easy to take, make available high potency dietary supplementation at low cost.

# UPJOHN VITAMINS

Upjohn
KALAMAZOO 99, MICHIGAN

FINE PHARMACEUTICALS SINCE 1886

DO MORE THAN BEFORE — KEEP ON BUYING WAR BONDS

## The EMIC Program in Massachusetts

The director of the Division of Child Hygiene, Massachusetts Department of Public Health, recently published the results of the first year experience of that program in our neighboring State.* This year was completed September 2, 1944. There were approximately 85,000 deliveries during that year in Massachusetts and 14 per cent of these came under the EMIC program, 4,421 cases were completed during the year, with a payment of $424,543.48. Of this amount, 58 per cent went to hospitals, 40 per cent to physicians, and 2 per cent to miscellaneous charges. The average payment to physicians was less than the $50 fee allowed for complete maternity care because of the fact that some patients moved from Massachusetts, so that they were under a physician's care in that State only a short time. Also, at the beginning many patients were admitted late in their pregnancy, and therefore did not receive complete maternity care under this program.

There were 4,172 live births, 96.5 per cent full term and 3.5 per cent premature. There were 7 maternal deaths during or after delivery, a rate of 1.7 per 1,000 (the 1943 rate for Massachusetts was 2.0).

*New England Journal of Medicine*, July 26, 1945

## New York Hospitals Bill For X-ray Services

Congratulations and thanks are due the Hospital Association of New York State. Last fall the Association adopted a resolution to the effect that radiology and pathology would be dropped from Blue Cross benefits when medical service plans were prepared to furnish these medical services among its benefits on a fee basis.

Last month the Association announced the following agreement with the Medical Society of the State of New York:

"(a) It is agreed that pathology, anesthesiology, roentgenology and physical therapy are medical services and the practice of medicine.

"(b) That these specialties are so recognized.

"(c) That an equitable arrangement can be made between the individual hospitals and the doctors who practice these four specialties recognizing the above principle, whereby the hospital may bill for these services in the name of the person rendering the service. (This can be done by inserting the name on the regular hospital billhead: i.e., instead of x-ray, indicate "Professional services of Dr. ———, roentgenologist.")

"(d) Until such time as a Medical Service Plan is available, there is no objection to inclusion of these medical services in the hospital service plan contract as long as the principle of recognition and proper remuneration to these specialists is carried out."

# NEWS
## *from County Associations*

### Hartford

C. Charles Burlingame, psychiatrist-in-chief of the Institute of Living at Hartford, was the speaker recently before the New York City Nursing Council for War Service. Dr. Burlingame's subject was "Readjustment and Contribution of the Returning Nurse Veterans in the Post War Period."

Leverett D. Bristol of West Hartford is the author of "Value of Health Examinations in Industry" published in *The Journal of the American Medical Association*, June 30, 1945.

On June 1 Mr. Berger Foss became director of Newington Home for Crippled Children, a 200 bed orthopedic children's hospital at Newington, Conn. He replaced Miss Constance Leigh who retired after 27 years' service in that capacity.

Mr. Foss came to Newington from the Knickerbocker Hospital, New York City.

### Middlesex

Major Lee D. Van Antwerp, AUS, of Meriden, at present at Borden General Hospital, Chickasha, Oklahoma, is the author of "Kappa Lambda, Elf or Ogre?" published in Bulletin of the History of Medicine, April 1945.

### Tolland

Mrs. Emma B. Smith has been appointed superintendent of the Rockville City Hospital.

Mrs. Geneva L. Wayland has been appointed superintendent of the Johnson Memorial Hospital in Stafford Springs.

John E. Flaherty of Rockville has been elected chairman of the State Fish and Game Board. He will serve for two years, succeeding Francis L. Shean

# Effective • Convenient • Economical

THE effectiveness of Mercurochrome has been demonstrated by more than twenty years of extensive clinical use. For professional convenience Mercurochrome is supplied in four forms—Aqueous Solution in Applicator Bottles for the treatment of minor wounds, Surgical Solution for preoperative skin disinfection, Tablets and Powder from which solutions of any desired concentration may readily be prepared.

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is economical because stock solutions may be dispensed quickly and at low cost. Stock solutions keep indefinitely.

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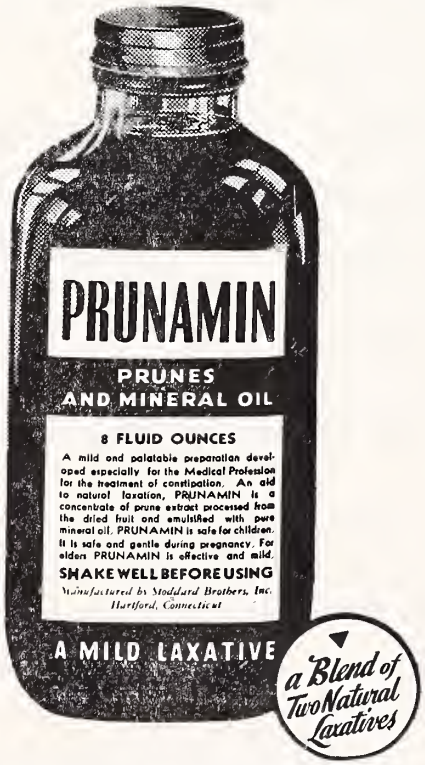
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# PRUNAMIN

- Two natural laxative ingredients (concentrated prune juice and pure mineral oil) blended into a mild, safe and effective aid to the correction of constipation.
- No harsh irritants . . . Just prunes and mineral oil, thus, PRUNAMIN can be recommended safely for young and old. No oily taste . . . only the flavor of rich Santa Clara prunes.




- PRUNAMIN was developed by Stoddard Brothers* at the suggestion of a group of physicians and now, after months of careful testing we submit this product for your consideration.
- We would be pleased to send samples upon request. Simply take one of your prescription blanks and mark on it, "PRUNAMIN PLEASE" and mail it to us today.

*Manufacturers of
Silver Birch Dry Prune Juice.
STODDARD BROTHERS, INC.,
501 Windsor St., Hartford 5, Conn.

of Bridgeport who was reappointed by Governor Baldwin to a six year term as a board member. Dr. Flaherty is a well known Connecticut sportsman, prominent in organizing field trials for hunting dogs.

# News from Yale University School of Medicine

Herbert C. Miller, formerly assistant professor of pediatrics at Yale University School of Medicine and associate pediatrician to the New Haven Hospital, assumed his new duties on July 1 as professor and head of the department of pediatrics, University School of Medicine, Kansas City, Kansas.

Edwin A. Lawrence and Philip S. Brezina, both members of the Department of Surgery, are the authors of "Carcinoma of the Oral Cavity" which was published in the *Journal of the American Medical Association* August 4, 1945. The authors, in this ten year study of 145 consecutive cases of cancer of the oral cavity in a general hospital, arrived at the conclusion that cancer of the mouth is easily accessible so far as treatment is concerned. However, they found that the five year survival rates are no better than for disease in some of the more inaccessible organs such as stomach and large intestine.

# NEW BOOKS IN REVIEW

*TOTAL WAR AND THE HUMAN MIND: By Major A. M. Meerloo,* M.D., F.R.S.M. *New York: International University Press, Inc.* 1945. 78 pp. $1.75.

Reviewed by Stanley B. Weld

This is one of the unusual books which the present world upheaval has been instrumental in producing. Written by a Dutch psychologist, also a doctor of medicine, who spent two years in Occupied Holland under the Nazis, it affords a grim picture of the physician's life in those drab days. The opening chapter gives in detail an excellent picture of two such days.

The author is a psychologist and analyzes for the reader the reactions of his fellow countrymen to the German occupation, the peculiar German psychology comprising an outward discipline and an inner disorder, and the various psychological weapons utilized by Hitler to overcome his enemies. The effect of fear, the psychology of courage and the phenomena of delusion and mass delusion are discussed. There is no doubt that the writer has emerged from his experience a strong proponent of democracy. Observations such as these are frequent: "Thus we have within each one of us the seeds of democracy and Fascism, and thus the struggle for the democratic or authoritarian attitude to life is fought out in each individual. . . . For it is only democracy which appeals to the adult in the individual; Fascism tempts his infantile desires." "Democracy must face this task of preserving the mobility of thought, in order to free it from blind fears and from magic. The clash of opinions which is characteristic of democracy may not directly produce truth, but it prepares the way."

In the closing chapters the author sounds a timely warning against the German preparation for yet another war. Should you doubt such a possibility, read the discussion of the forms such preparation may take and the three fundamentals necessary for any successful reconstruction.

"Like his primitive brother, twentieth-century man is engaged in total war with his environment. Obsessed as he is by fear, he can find rest nowhere in the world. The material basis of his life has gone, dwindling away through a series of great economic crises. Even the air he breathes, and the sky to which he turns his eyes, are no longer safe, for the winds may carry poisonous gases, and the sky rain down bombs. Treaties are broken, promises are not kept, and the very gods no longer are the same."

How true! And only today the voice of a woman over the radio, just returned from a visit to one country after another in Europe and Asia, informed us that the thing which impressed her most was the fact that everywhere there is no peace.

*A MANUAL OF SURGICAL ANATOMY*: Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, by *Tom Jones* and *W. C. Shepard. Philadelphia: W. B. Saunders Company.* 1945. 195 pp. with 267 illustrations on 138 figures, 153 in colors. $5.00.

Reviewed by John C. Mendillo

From a surgical viewpoint, this textless manual of surgical anatomy, prepared by two eminent anatomical artists cannot be outdone. This concise atlas, prepared under the auspices of the Committee on Surgery of the National Research Council, is valuable and well illustrated.

The critical selection of the dissections and the surgical approaches shown are of inestimable value to the military surgeons and busy traumatic civilian physicians. The volume is designed to refresh the memory of anatomical features likely to be met with in operations on any part of the body. The book is divided into four parts: namely, the head and neck, the trunk—thorax, abdomen and pelvis, the upper extremity, and, lastly, the lower extremity. All four parts are profusely illustrated and featured by having the names on the various structures themselves rather than placing them at one side.

In addition to all this, all sections illustrate various incisional approaches and anatomical features present in these dissections.

The illustrations of the typographic anatomy of the lungs are very lucid and up to date. This is true of the sympathetic

nervous system and its surgical approaches.

The charm of this volume lies in its compactness and in the simplicity of its proved and established operative procedures of surgery and most of its specialties.

The illustrations are beautifully drawn and extraordinarily complete.

*PREVENTIVE MEDICINE: By Mark F. Boyd*, M.D., MS., C.P.H., Field Staff Member, International Health Division, Rockefeller Foundation; Formerly Professor of Bacteriology and Preventive Medicine in the Medical Department, University of Texas. Seventh Edition, Revised. *Philadelphia: W. B. Saunders Company*. 1945. 591 pp. $5.50.

Reviewed by IRA V. HISCOCK

Salient features of preventive medicine are clearly presented in condensed form in this revised edition of a widely known text, designed primarily for medical students and practitioners. Preventive medicine is here defined as that branch of applied biology which seeks to reduce or eradicate disease by removing or altering the responsible etiologic factors.

Many sections have been rearranged and rewritten to include advances in knowledge during the past five years. For example, discussion of the encephalitides has been expanded; the section on nutrition has been revised; and consideration of rheumatic fever, leptospirosis and asbestosis has been added. As the author suggests, condensation may have resulted in inadequate coverage of important subjects. This is perhaps illustrated in almost complete omission of the important role of the public health nurse in tuberculosis control and in only brief reference to the physician's opportunity for health education and for significant service on boards and committees of medical and health agencies. Major elements of a public health program are summarized in the final chapter, as well as having been discussed elsewhere. In comparison with a recent report of the American Public Health Association, the author is over conservative in stating the minimum financial requirements for an efficient local health department.

This volume comprises eight major divisions with 37 chapters and an extensive, well selected bibliography. The text is effectively supplemented by 187 illustrations and 57 tables drawn from many sources. This book will be a useful reference text for students of preventive medicine as well as for practicing physicians and health officers.

*THE 1944 YEAR BOOK OF RADIOLOGY*. Diagnosis, Edited by *Charles A. Waters*, M.D., Associate in Roentgenology, Johns Hopkins University; Assistant Visiting Roentgenologist, Johns Hopkins Hospital. Associate Editor *Whitmer B. Firor*, M.D., Assistant in Roentgenology, Johns Hopkins University; Assistant in Roentgenology, Johns Hopkins Hospital *On leave with the Armed Forces. Therapeutics, Edited by *Ira I. Kaplan*, B. SC., M.D., Director, Radiation Therapy Department, Bellevue Hospital, New York City; Clinical Professor of Surgery, New York University Medical College. *Chicago: The Year Book Publishers, Inc.* 448 pp. $5.00

Reviewed by ROBERT M. LOWMAN

*The 1944 Year Book of Radiology* follows the general plan of previous volumes in the presentation of abstracts of articles appearing in the radiological literature during the past year.


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This latest edition to the series of *Year Books of Radiology* is a volume containing 450 pages and includes material which appeared during the latter part of 1943 to the middle of 1944.

As pointed out by the editors, the task of obtaining interesting and profitable articles during this period has been most difficult. Much of the interesting material previously reviewed from the Swedish and German literature is absent because of the unavoidable limitations imposed by war.

Despite this, the 1944 volume compares favorably with the previous *Year Books*. The abstracts are good, presenting the contents of the original articles in fair detail. The intriguing radiological practice quiz of twenty questions introduced in 1943 is again presented. It should be made a part of the printed volume in addition to appearing on the cover. There is, however, a sharp and noticeable reduction in the valuable editorial comment of the abstracted articles in the diagnostic section.

The volume is divided into two main divisions, *Diagnosis and Therapy*. The excellent plan of previous years of classifying the material on an anatomical basis is again used. The selections are well chosen and the presentation of numerous and well reproduced illustrations adds greatly to the text. A comprehensive index is appended. As in 1943, Dr. Kaplan has produced an excellent and stimulating review of the entire field of radiation therapy in an introduction of thirty-nine pages.

As long as worthwhile articles are published in radiologic journals, a need will exisit for abstracting and presenting these papers in a convenient form for the busy man. This need is met by this *Year Book*.

The physician is well rewarded for the time spent with this interesting and instructive 1944 *Year Book of Radiology*. It is recommended to all physicians without qualifications.

*TECHNICAL METHODS FOR THE TECHNICIAN. By Anson Lee Brown*, A.B., M.D., Director of Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians, Columbus, Ohio. *Published by the author.* 1944. 675 pp. $10.

Reviewed by FRIEND LEE MICKLE

This volume of over 700 pages appears to be the author's outline which he uses in teaching at a school for technicians. In the hands of a skillful teacher the volume might be very useful but it is doubted that it will have extensive use in the hospital laboratory or that it would always be used to advantage by technicians without outside guidance. For the third edition the text has been considerably revised with new material added. New illustrations and color plates should make the text more understandable to technicians and it is refreshing to find original drawings not copied from other sources. The colored plates and drawings, particularly those for blood work, are especially clear for the teaching of persons with no previous training. A newly added section entitled "Important Laboratory Data" is in effect an appendix of information in tabular form that should be useful for reference. Even experienced technicians would do well to heed the suggestions given under "Laboratory Behavior" and "Habits."

The binding, printing work and paper are fair for a war-

time publication. Many errors in the volume indicate carelessness in editing and proof reading. To give only one example, in the table on "The Derivation of Words" (page 655) nine lines in two of the three columns of the table have been interchanged so that portion of the table is valueless and misleading in the information it furnishes.

A multitude of tests are described apparently for the reason that the technician may at any time be called upon to use them but in doing so techniques of laboratory methods of little value have been included indiscriminately along with more reliable procedures in such a way that the reader has no way of evaluating the usefulness or acceptability of any method. In listing complement fixation tests and flocculation tests (page 660) names of tests are given that are not widely accepted as reliable tests and that might better be omitted. The author has presented at some length a test of his own for syphilis, thus adding without any apparent reason to the far too many tests for this purpose.

When a movement is on foot to encourage the use of correct scientific nomenclature, it is unfortunate to have technicians taught that there are such organisms as Bacillus Paratyphoid A, Bacilius Friedlander, Bacillus Coli and Bacillus Tuberculosis especially when there are well recognized names for the species the author is attempting to describe. Also, in naming etiological agents the author seems to follow no well recognized system and the frequent capitalizing of the species name throughout the volume is unfortunate and annoying even in a book intended for technicians. Too, names of etiological agents are used somewhat carelessly, one example being the use of "Hyenolepsis Nana" as the name for the dog tapeworm. The parasitology is in general rather poorly presented.

The author is to be congratulated on emphasizing to technicians throughout the volume that the success or failure of laboratory work depends upon technique. He has described apparatus well in terms the technician should understand and has given specific directions, well outlined, for performing laboratory tests. Lists of questions at the close of chapters make it possible to review what has been discussed by subjects.

*YOUR HAIR AND ITS CARE. By Oscar L. Levin,* M.D., and *Howard T. Behrman,* M.D. *New York: Emerson Books, Inc.* 1945. 184 pp. $2.00.

Reviewed by MAURICE J. STRAUSS

Apparently written for the lay public with the idea of telling how to properly care for the hair and scalp, the authors seem to have missed their mark somewhat. In the chapter entitled "Care of the Scalp" they have done an exceedingly good job of telling how one should care for the scalp and hair, and in several succeeding chapters they have made clear the fact that there are many causes for the loss of hair and that the differentiation of these causes is the province of a physician.

Drs. Levin and Behrman's failure consists of including too much scientific material. The lay reader will doubtless enjoy reading that, but he probably will end by being just as confused after reading the book as before. There is an excellent last chapter giving brief answers to some of the many questions that are frequently asked about the hair.

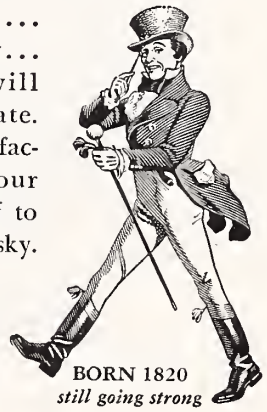



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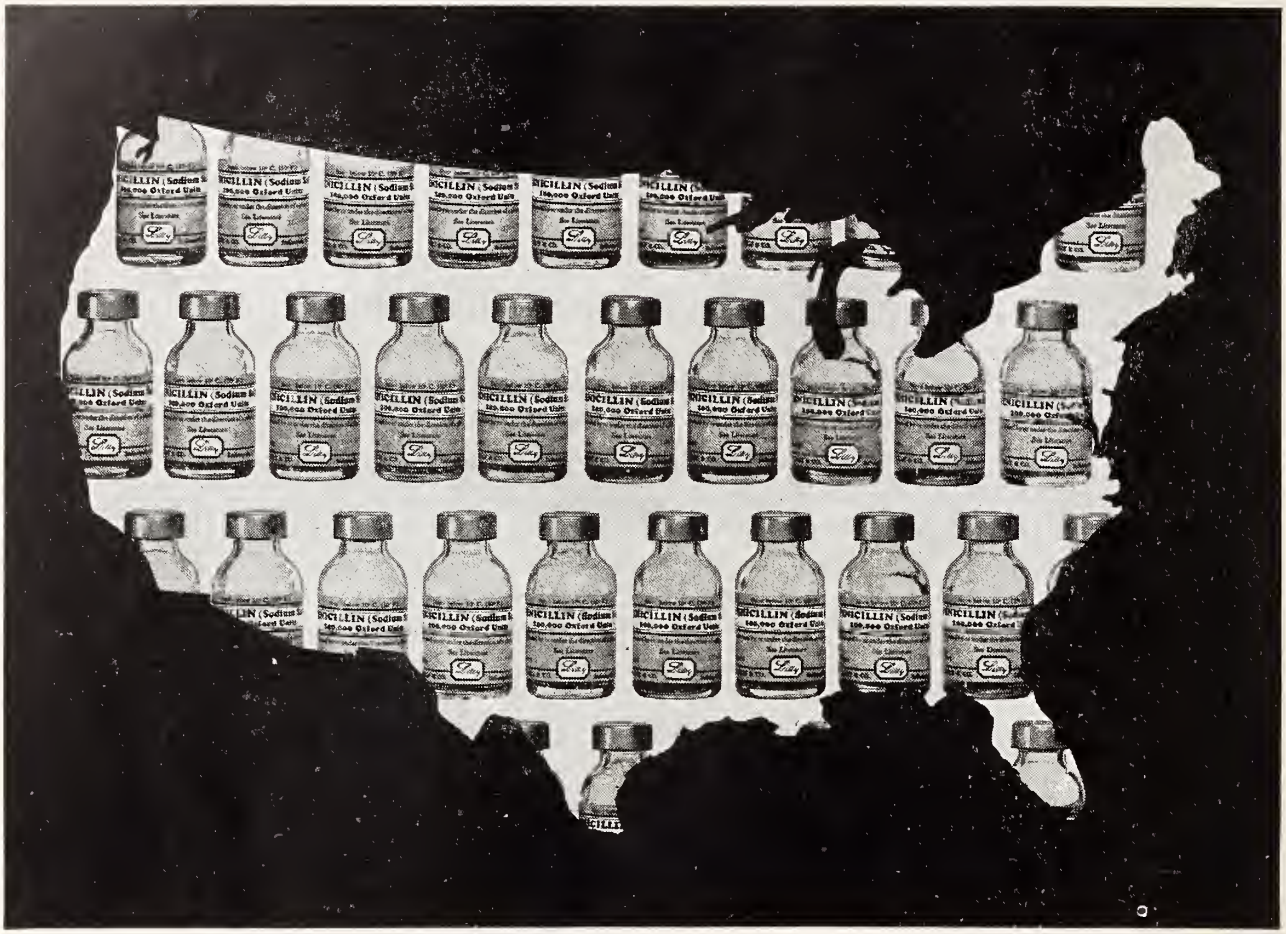
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# HOSPITALS AND DOCTORS REVIEW BLUE CROSS PLANS
## (Hospital Service Insurance)

L. Henry Garland, m.d., *San Francisco*

The Blue Cross plans—the modern way of budgeting the cost of hospitalization while sick—are growing by leaps and bounds. Non-profit hospitals of this country are helping the American worker to insure himself at small cost against the hazards of a large hospital bill. The physical protection of his policy is equalled only by the mental relief he enjoys as its possessor.

The plans have now grown so great, and encompassed so many million citizens, that the time has come when the profession and the hospitals should quietly review experiences, appraise trends, and evolve desirable revisions.

### The patient's welfare

The first and foremost interest of the practicing physician and of the hospital administrator is the patient. The patient must be provided with hospital accommodations as reasonably as possible, as comfortably as possible and as complete as possible. Many patients must be educated to the fact that simple adequate hospital accommodations are just as good for their physical welfare as luxurious private rooms. If they can grasp this simple fact, they will not only save themselves a lot of individual expense today, but will aid in establishing lower premium rates for hospital plans in the future. It is a sad commentary that approximately 60 per cent of hospital plan subscribers at the present time choose more luxurious accommodations than their policies call for. They pay the balance between the sum allowed them under their policies and the sum due for the accommodation. In most instances the luxurious private room is not essential for the patient's recovery and adds an unreasonable burden to his expenses. This is a problem which will gradually solve itself as patients and the public realize how comfortable small ward accommodations can be.

### Protection of the hospital

It is essential that adequate reserves be built up in all existing plans in order to anticipate the burden of epidemics, the burden of rising costs and the burden of new developments in hospital technique. The proper proportion of reserves to total subscribers is difficult to estimate at the present time, but it obviously seems wise to err on the side of safety and set up reserves in really large amounts. It is satisfactory to note that as small a plan as Hospital Service of California which centers around the San Francisco Bay district and has approximately 30,000 subscribers, already has a reserve of approximately $150,000. When reserves reach a suitably large point the public should and undoubtedly will be given the benefit of lower premiums. Lower premiums, making the plans available to more low wage subscribers, would seem more sociallydesirable than extending the benefits beyond the customary twenty-one days of hospitalization.

### The medical profession

Most, if not all, of group hospitalization or Blue Cross plans were started through the direct personal and financial assistance of the medical profession. Indeed, in many plans the first four or five hundred policies sold were purchased by physicians in order to give the plan a start. These same physicians urged their patients and the public at large to purchase such sound coverage. They appreciated the psycological as well as the physical benefits of hospital insurance and supported these plans since their inception.

Inasmuch as the term "hospitalization" is assumed to cover more than "hospital service" by some institutions, physicians have been in constant study of desirable services to be included along with hospital benefits. Physicians on hospital staffs realize that no medical services should be included *as a part* of hospital services, but that it may be wise to provide for some medical services *along with* hospital services, for the convenience and well being of the patient. When such professional services are included along with hospital services the method of reimbursing or paying the physician for his services becomes of considerable moment inasmuch as it is the public's money which is being spent, and the public desires assurance that its funds are being spent on the best type of medical care available.

In general, the least controversial and most satisfactory Blue Cross plans have been those in which straight hospital care alone was furnished the patient; these plans are the cheapest on the market today and are well exemplified by those in Kansas City, Washington, D. C., and St. Louis. When local authorities desire to include certain medical services (such as roentgenology, clinical pathology and anesthesiology) along with hospital services, then the following points representing the considered opinions of the American Medical Association and the American College of Surgeons should be borne in mind:

1. The medical profession approves hospital service insurance associations which issue straight hospital service policies (for example the hospital contract issued by Hospital Service of California and the Associated Hospital Service of Southern California in conjunction with California Physicians Service).

2. It does not approve of any hospitalization contract which provides any medical services as a part of hospital care. Medical benefits including roentgenology, pathology, and anesthesiology, may be provided only on a basis under which the subscriber is indemnified for these expenses.

3. When hospital service insurance associations issue hospital service contracts which include indemnification for diagnostic medical services, it is desirable that such be specified in the description of the contract (for example: Hospital service contract and limited professional service contract). Further, it is desirable that the association issuing such contracts make specific arrangements whereby the benefits for radiology or pathology are payable on waiver by the subscriber to the physician rendering those services, or directly to the subscriber. In this manner the hospitalization association will be complying with the letter as well as the spirit of indemnification.

4. The medical profession, through its national and state organizations, has emphasized that it does not approve or endorse any hospital service contracts which purport to provide any medical services as a part of hospital care, nor can it countenance the issuance by any hospitalization association of advertising literature which fails to indicate that payment for medical services is being made to physicians rendering such services. It is important for the welfare of the public, the hospitals, and the medical profession that a clear distinction be made between hospital service and medical service in any and all of these hospitalization insurance contracts. (See also Calif. and West Med., Nov. 1941).

## THE FUTURE

It is desirable that the cost of hospitalization insurance be gradually lowered until it can be purchased by at least 75 per cent of working and white collar classes.

It is imperative that a clear distinction be maintained between hospital services and medical services. On the whole, it is desirable that Blue Cross hospital policies be limited to hospital benefits exclusively. Those now selling more than hospital services should be revised accordingly.

Under no circumstances should Blue Cross plans be extended to cover further medical services of ambulatory patients. This is of extreme and obvious importance. The medical profession has already taken steps to provide medical benefits to patients both inside and outside the hospital, as exemplified by California Physicians Service and Michigan Medical Service.

It is desirable that the period of hospitalization coverage for certain sicknesses be extended and perhaps that coverage be developed for individual subscribers.

## SUMMARY

It is desirable that hospital Blue Cross plans gradually revise their rules and regulations so as to conform with the considered recommendations of the American Medical Association and the American College of Surgeons. It is to be noted that most of these plans are still less than five years old and that to date no single plan has been officially approved by the organized medical profession. (The Amer

can Medical Association.) Such approval is desirable from every point of view, including salability.

With such approval it will not be long until enlightened hospital groups see that the medical profession is adequately represented on the boards of directors or boards of control of all individual plans, along with representatives of the public and the hospitals.

It is a fact, not yet fully realized, that many hospital plans have no coordination with local county medical societies or state medical organizations. This is a serious omission and one that should be rectified as soon as possible. In the final analysis it is the medical profession which transforms a building from just a hotel or a pest house into a living institution for the healing of the sick, a modern hospital.

# RESTORING THE INDUSTRIALLY INJURED

Stanwood L. Hanson, *Boston*

The Author. *Assistant Vice-President Liberty Mutual Ins. Co.*

Both industrial concerns and insurance companies are interested in the early restoration and return to work of employees who have become disabled as the result of industrial accidents or diseases. Over the past thirty years a great deal of study has been given to improved methods of preventing industrial accidents and eliminating the hazards of industrial disease, and new and better forms of surgical and hospital treatment have been developed for these industrial injuries. These studies have been in progress because they are humanitarian and necessary to prevent loss of life and suffering and to minimize the financial loss which ensues from prolonged disability.

The war, however, has produced a brand-new demand and stimulus to this subject of elimination of industrial loss resulting from accidents and diseases. I refer to the great demand for manpower in industry. Early in the war we recognized the need of industry to employ every person who could possibly work and to restore injured persons as early and as completely as possible. We accordingly began to make renewed studies in rehabilitation to see if there did not exist techniques that could be coordinated into methods of bringing about earlier and more complete restoration of injured workers and to see if there did not exist more scientific methods of adapting and placing handicapped persons in industry to be safe and productive workers. It was our feeling that the industrially injured were generally receiving excellent surgical and hospital care but that recovery frequently bogged down in the convalescent period and that some cases did not get back to work because of the absence of a good introduction to work activity or appropriate placement when physical handicaps had resulted from the injury.

As you all know, the usual process of treatment of a serious industrial injury was to get the employee into the hands of a good physician or surgeon and into the hospital. Our experience has been that injured workers, as a general rule, make good surgical recoveries, receive excellent hospital treatment and are discharged from the hospital well on the road to recovery. The surgeon or his assistant then usually directs after-care treatment in the form of dressings and often in the form of some applied heat and massage in a physical therapy laboratory, perhaps under medical supervision and perhaps not. The patient also occasionally received some instructions from the physician with regard to exercise and activities, but little or no supervision in carrying them out.

We have recognized that inactivity prolonged disability, and it sometimes developed discouragements or bad mental attitudes. Physical or mental fixations often resulted which produced permanent or partial disability. No facilities have existed, however, for giving a medically supervised after-care to industrial cases that would prevent the development of these fixations. The reason that the medical profession and hospital services have not provided facilities for this service is probably because there has been no recognized demand for them. Nevertheless, we felt there was a "missing link" in the restora-

*Presented at the Industrial Health Conference, Hotel Taft, New Haven, Connecticut, December 14, 1944*

tion program and that actually there needed to be a continuity of treatment all the way through from the time of the accident to the actual return to work. In an effort to supply this "missing link" on workmen's compensation cases, we started to examine existing physical therapy departments and curative and sheltered workshops, both in this country and in Canada. Many of them we found to be operated by technicians without medical supervision, but still they appeared to be getting some good results.

The greatest success that was reported was that which was being obtained in the Royal Air Force. There they were giving a medically supervised after-care treatment in the form of physical therapy and exercise that was started almost immediately following surgical operations. Men were given activities to do in bed and more activities as soon as they could hobble around the hospital wards. From there they went to the gymnasium, the swimming tank, the tennis courts and the golf course even though they might have to limp about with a cast or a crutch. As a result, they were restored to fighting ability much more successfully. These men were invaluable and nothing was spared to bring about their recovery, and in so doing, the value of these techniques appeared to be proved.

For the purpose of providing a facility where doctors could send the industrially injured to receive medically supervised after-care and convalescent treatment, Liberty Mutual Insurance Co. opened a Rehabilitation Center in Boston in June, 1943, for the benefit of injured employees of our New England policyholders. This is a place where employees can receive physical therapy in the form of heat, massage, whirlpool bath, and physical therapy exercises. Concurrently they receive ocupational therapy which consists of prescribed work in the carpenter shop, machine room, paint shop, or on the printing press, and muscles are thereby re-educated to usefulness and stiff joints restored to activity. Recreational therapy is also provided and can be applied for mental stimulus and encouragement as well as for diversion. Patients who are admitted to the Center remain all day and the Center is open five and a half days a week.

For a man who is suffering with a severe contraction of the wrist and fingers as a result of burns, a typical day at the Center might start with a physical therapy treatment in the form of immersing his forearm in the whirlpool bath of warm water which provides a gentle massage and heat, and thereby stimulates blood circulation. He might also receive some additional physical massage to the injure member by the therapist and be given some exercise on hand and finger grips which test the daily im provement that the man might be making in exten sion, rotation and flexion of the wrist and finger From the physical therapy department he woul then go into the carpenter shop which is a cheerfu room resembling a manual training room in a hig school. Here, for the purpose of being given activit that is interesting and for the purpose of gettin motion into the hand and fingers which the docto wishes him to recover, he may be given the task o making a corner cabinet out of wood for his wif He will have to use planes, hammers, saws, perhap screwdrivers and chisels, that will give him a wid variety of grasping, extension and rotation of th hand and wrist; and the occupational therapist may in addition, put a good deal of emphasis on the us of sandpaper blocks which may be so designed an made for this individual that they will encourag the very kind of grasping power that he needs t recover. When his injured hand becomes fatigue the therapist will send him to the rooms that are se aside for recreational therapy. Here, complete res may be prescribed for a period or he may be encour aged to play checkers or shoot pool which migh give his injured fingers and hand further mild activ ity and exercise. For different injuries there ar provided a wide variety of tasks in woodwork an metal work as well as competitive and recreationa games.

We believe that we have learned what the Roya Air Force learned and what our own medical de partments in our Air Force, Army and Navy ar reporting—that is, that earlier and more complet physical restorations are brought about when medi cally supervised activities are carried out in a con tinuity of after-care treatments. Of the first 9 cases whose records were closed at the Center, 4 patients were restored to full ability to work; 2 were restored to sufficient ability to do light work 13 were referred for further surgery after a perio of treatment; one was referred to the State to receiv vocational re-education; 8 dropped out of thei own volition and would, therefore, be considere failures; and 4 were discharged as cases that we could not help and were accordingly considere failures. This means that over 70 per cent of the cases which were admitted, all of which were seri ous injuries, were either fully or partially restored to work capacity.

The end of the war will, of course, bring to an

end the vital need to restore men to fighting ability, and it may well reduce the demand for workers of every description in industry, including the physically handicapped. I do think, however, that there is going to be a growing demand for hospital and community services that can provide a continuity of treatment for serious injury cases. Hospitals could provide it both as an in-patient and an out-patient service. Only a comparative few of our larger city hospitals maintain departments in physical therapy where heat, massage, and hydro-therapy can be applied. It is only in extreme instances that hospitals have a department in occupational therapy where the stimulus and interest of work activities can be prescribed. There is a growing demand for such facilities both by industry and by insurance companies for the reduction of loss. There is certainly a need for more of them to accomplish the humanitarian task of restoring the disabled, and there is certainly going to be a need for them to meet the problem of restoring and re-restoring wounded and handicapped veterans over the immediate years that lie ahead.

Here is a challenge to the medical profession and to hospital services to find a way to practically provide these more complete services for physical restoration, the pattern for which is being designed in some of our schools of physical and occupational therapy, in some of the community workshops, and by the Medical Corps in our armed services.

# NUTRITIONAL EDEMA

ABRAHAM O. WILENSKY, M.D., *New York*

NUTRITIONAL edemas have only come under intensive study in the past few years. In clinical medicine this condition is found as follows:

1. With the general undernourishment incident to widespread warfare and in times of famine localized to certain backward segments of the world, cases of starvation protein deficiencies (hypoproteinemia) occur with subsequent states of general edema. Considering the number of persons involved in such widespread geographic areas, the number of cases reported of nutritional edema is not large. This seems to be corroborated in the published pictures of inmates of concentration camps, in which the pictures show individuals emaciated down to skin and bones. But none of them shows gross evidences of edematous states. It seems then that some other factor is necessary besides starvation to produce states of nutritional edema.

2. In ordinary civil practise, one occasionally sees patients who have general—subcutaneous, serous cavity, etc.—edema without the evidence of the usual forms of pathology which produce such water logging. They have no elicitable manifestations pointing to nephritis, hypertension, cardiac disease, cirrhosis, myxedema or a malignant growth, and there is no gross evidence of a state of deficient nutrition or starvation.

The one objective finding that one can uncover is that the latter patients have moderate or excessive degrees of hypoproteinemia sometimes as low as 4.5 gms. per cent of the total serum protein.

Under any of these two basic conditions, the mechanisms is definitely a physico-chemical change in the distribution and retention of fluid in the body.

Starling was the first to call attention to the part played by the osmotic pressure of serum proteins in regulating the interchange of fluid between the blood stream and the tissues.

The Starling hypothesis has helped to explain these clinical conditions. Sufficient available protein helps to maintain a normal colloidal osmotic pressure in the blood stream, and in the capillary bed. Protein deficiencies are not thought to disturb the physico-chemical conditions to the extent that water is retained in the body tissues with the formation of edematous areas, and in the hollow spaces with the accumulation of effusions. This change causes more or less reduction in the amount of urine secreted, causes states of hemo-concentration, and facilitates pseudo-obstructive manifestations. Nutritional edema and the otherwise obscure accumulations of fluid in the hollow spaces and cavities are only understood on this basis.

Occasionally similar forms of general edema occur when the total serum protein level is apparently in the normal range. In these seemingly paradoxical

cases, it is found that the albumin fraction is low and that the globulin fractions are increased; that because the osmotic pressure of the globulin fraction is much lower than that of the albumin fraction, there is a lower total osmotic pressure; and that this disturbed physico-chemical relationship permits fluid to accumulate in the tissues and hollow spaces.

In the cases in ordinary civil life which the author has seen, there is much reason to believe that underlying all of this abnormality is a disturbance of liver function associated with a latent or demonstrable liver parenchymal disease. Essentially, there seems to be difficulty in the production of proteins—a function of the liver cell—and its retention in the body, as evidenced by the rapid excretion of protein when this is supplied in sufficiently over abundant quantities by all known methods—food, blood or plasma transfusions, etc. Frequently, in addition, one can detect abnormalities in liver function by the various laboratory tests. It is added proof that the disturbance is corrected and/or controlled with difficulty and is time consuming because of the unknown original cause of the anatomical change in the liver parenchyma and of the consequent functional impairment.

Reference in the recent literature to the attempted use of thiamine is interesting because the occurrence of the "wet" forms of beri-beri falls in with the other known facts. There is much undernourishment and wasting in beri-beri and this eventually must cause deficiencies in the protein content. The sequel then is quite obvious. In addition thiamine formation probably takes place in the liver so that the whole ties up very well together. Again it seems that the essential disturbance is deficient protein formation and retention.

Elsewhere the author[1] has gone over the question of the interrelationships of latent or demonstrable liver disease, of fatigue, or lessened resistance to injury and disease both in civil and military life, and to fatigue in industrial practise. These are all important factors especially nowadays.

It seems that for the present one must treat this condition empirically. All that we are able to do for the present is to replace the needed protein to build up the proper amount of body protein and the proper amount of necessary reserve proteins. In any case protein replacement therapy should always be carried out under proper laboratory guidance. It should be understood that each case is a feeding problem in itself and gains or loses in importance in accordance with the relative acuteness or chronicity of the disturbanec and with the information received from continued laboratory study. The sources from which replacement is to be made include food, transfusions of blood, plasma, transudate fluids, and oral or parenteral protein digests. One should rely upon these methods until the cause of the disability is made clear.

In calculating the daily necessary amount of protein, the following factors must be considered: (1) the patient's nitrogen balance; (2) any estimated deficiency in the tissue and reserve protein; and (3) it is advisable to consider not only the degree of protein deficiency, but also the possible continuance of the original disability which cause the deficiency. Finally, an additional amount should be given because of any unavoidable error in the computation.

In bad cases one may follow the same rule of thumb as one frequently does with abdominal drainage—whenever in doubt, give more, and in very bad cases one should give as much as possible by every available channel and method up to the limit of tolerance.

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# A GRIPPE SYNDROME

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ABOUT eight years ago reports began to come in of an acute gastroenteritis of short but violent type. It was and is still popularly known as "Twenty-four-hour Intestinal Flu." Later these recurring outbreaks became more common and were often blamed to various causes from polluted water supply and ptomaine poisoning to psychic stress. Those cases which have been more prolonged were hospitalized and given a thorough workup. The findings were interesting, mostly from a negative point of view.

There is no seasonal peculiarity. In the summer of 1943 the cases were so numerous that "Summer Grippe" seemed to be an appropriate name, but when the cases continued numerous so that the afflicted were blaming their Thanksgiving, Christmas, and New Year dinners for their attacks it could hardly be called by that name. Among closely associated groups such as those in war industries, training camps, and schools, there have been limited outbreaks that make one feel that it is highly infectious. Children, most young adults, pregnant women, and those leading a vigorous outdoor life recover more quickly. Elderly people, those less vigorous or those with some chronic condition, especially elevated blood pressure, have a more stormy and prolonged illness. Beside those that are violently ill in the gastro-enteric phase there are many that are mildly affected with vomiting and diarrhea but able to continue their usual regime.

The most surprising observation is the persistence of this illness. If one considers it only from the violent attack of diarrhea and vomiting it is indeed very short; but a careful analysis of the cases shows that this phase is only a very small part of the entire picture. Apparently this is a syndrome which with all its associated symptoms may continue on for months and even years. Another observation is the tendency to a peculiar cyanosis which may be present in any of the acute phases whether or not the respiratory tract is involved at that time.

There are listed here the symptoms that are *always* found associated in this syndrome. First in importance is an upper respiratory infection which usually makes its appearance well before the gastro-intestinal attack. This is in the form of a common cold. It is sometimes very severe but may be so mild it is barely noticed. It is very persistent however, and in those cases which continue on with the other less commonly associated symptoms the respiratory infection never entirely disappears until the last phase has worn off, possibly months or even years later. The cramps with the vomiting and diarrhea complete the rest of this picture. This may be the entire story with a gradual disappearance of all symptoms and signs. There may be only diarrhea with cramps and nausea. There may be only nausea and vomiting with no diarrhea. These four symptoms may come and go for months and finally wear away. There may be no other symptoms severe enough to warrant attention.

With the passage of time it has been possible to make further observations of this illness. Beside the above four there are certain frequently associated symptoms that probably are part of the syndrome. Vertigo is a frequent accompaniment, as are acute and subacute bronchitis and pneumonitis. Esophagitis with marked substernal pain may simulate coronary disease. Otitis media, conjunctivitis, myositis, most frequently attacking the muscles of the back, neck and shoulder are very common. Bursitis, mostly subdeltoid, neuritis including parasthesias of the hands and feet are also very common. Neuritis with myositis often come in the left chest, causing the patient to worry about a heart involvement or a pleurisy. Laryngitis is not frequent but can be quite bothersome. Foul breath is for some reason especially associated with the myositis and neuritis phase. Borborigmus and spastic colitis associated mostly with the long intestinal phase of the illness may lead to the diagnosis of peptic ulcer, chronic appendicitis or other gastro-intestinal conditions.

Also occasionally observed are symptoms which may be purely incidental and could attack any individual over the period of time as protracted as some of these cases. The following are listed in the order of their frequency: lumbago, sacro-iliac pain,

*The Presidential Address, Fairfield County Medical Association, Bridgeport, April 10, 1945*

sciatica, any of the herpes, stomatitis, mental states with lethargy and confusion, proctitis, and the symptom complex of urticaria and angioneurotic edema. There is no ground for making a hard and fast claim that any of these frequently associated and occasionally associated symptoms are resultant of this illness; but frequent coincidence makes it seem very likely.

It will clarify the picture to cite one case that was typical: M. G. age 41. Reported June 13, 1943. A retail food merchant in good general health, had never had any serious illness. He claimed he was overworked and felt very tired. The findings were entirely negative except for injection of all upper mucous membranes and a blood pressure of 140/85. On September 11, three months later, he was suddenly seized with nausea, abdominal cramps and diarrhea before going to his business in the morning. He was violently ill. The temperature by mouth was 99; pulse 84; blood pressure 122/70. His throat was inflamed and along the anterior edge of his tongue the fungiform papillae were prominent like in a beginning strawberry tongue. He complained that since early spring he had not been free from symptoms of a cold and the malaise he complained of in June had persisted.

After the gastro-enteric episode on September 11 intestinal unrest persisted. He described a boring epigastric and substernal discomfort which was worse on waking in the morning. There was slight frequency of urination in October but the urine was negative. The constant sensation of an upper respiratory infection and intestinal unrest with borborgmus, irregular foul-smelling movements, epigastric distress simulating peptic ulcer, weakness, easy fatigability, vertigo, and one attack of prostration when he became very pale and had heavy sudation, finally led to his spending the month of February, 1944, in Florida. In the meantime he had attended his work continuously except for two days during the acute gastroenteric phase. His weight had stayed constant, his general appearance healthy, his blood pressure around 130/80, and a negative urine.

He was much better during his stay in Florida and for two weeks after his return, but the symptoms did not entirely disappear. On April 3, 1944, a fresh attack punctuated by an exacerbation of the upper respiratory infection, vertigo, temperature 101.2; pulse 104; extreme weakness, and the abdominal unrest, led to his hospitalization for observation and a complete workup. A blood culture was negative; the urine was negative. A stool examination was not helpful but an x-ray of the chest showed a slight pneumonitis at the right base. A gastro-intestinal series and barium enema were negative except for spasticity of the colon. The blood count was normal.

His temperature dropped to normal promptly and after the rest in the hospital and the assurance offered by the complete check-up he was discharged home improved in one week. The following symptoms continued: depression, abdominal cramps, moderate diarrhea, easy fatigability. By January, 1945, his symptoms had gradually faded but a review at that time showed a slight lumbago, continued nasal congestion and pharyngeal irritation, restless dream-laden sleep. The intestinal unrest had entirely disappeared. Note that his weight of 154 was pretty nearly the same as when the illness began. His blood pressure was 122/62. A routine examination March 27 last revealed that all symptoms had disappeared.

As was previously noted, those patients who were suffering with this illness and were hospitalized for whatever reason were given what laboratory and x-ray review was deemed helpful in studying the nature of this disease. The findings were mostly negative. Three were found to have pulmonary findings interpreted as a pneumonitis or pneumonia. Sputum examinations gave no lead. Tests for undulant fever were negative. Those who had barium enema x-ray showed spasticity of the colon. The blood count varied according to the phase of the syndrome. Those suffering acutely with gastroenteritis had consistently elevated leucocyte count with a high polymorphonuclear differential. None of the stools examined for dysentery were reported positive.

Last June at the Chicago session a paper read by Reimann and describing the gastro-enteric phase of this syndrome warned of "much wasted effort in searching for sources of poisoning or for the usual bacterial causes of enteritis." He gave as his title: "Epidemic Diarrhea, Nausea and Vomiting of *Unknown Cause*."

There are three deaths which were very much hastened by this grippe syndrome. The most spectacular of the three was in the case of a business executive of 50 who was a hard-driving leader in the oil industry. His past history showed a chronic otitis media since having scarlet fever in his youth. He had always been underweight and although seldom really sick he had an occasional upper respiratory

infection with return of the discharge from his right ear. Last August symptoms of this grippe syndrome developed and continued through to his death in December. During this interval the following symptoms manifested themselves: extensive nasopharyngitis, myositis, vertigo, mental states, enterocolitis, bronchitis, and increasing blood pressure. A very rapidly developing nephritis overwhelmed the picture, with rising blood pressure and rising blood non-protein nitrogen. He died in uremic coma.

The second case was a much more rapid tragedy. This was a woman of 73 of robust health except for a chronic cholelithiasis which she had steadfastly refused to have operated. The illness took place in the fall of 1943 when it was epidemic and came in the form of violent gastroenteritis. The acute stage was quieting down nicely on the third day when a very rapidly developing cholecystitis set in, with operation and death.

The third case was in a chronic alcoholic woman of 68 who had suffered for years with extensive intestinal adhesions following an appendiceal peritonitis with operation. She had had two operations since for partial obstruction and was almost invalided with symptoms of mild residual obstruction, and of course, the chronic alcoholism. However, she remained thus for years, taking large quantities of vitamins, more or less contented doing Red Cross work in her room. Definite signs of this grippe syndrome in the form of a moderate upper respiratory infection, periodic nausea, slight fever, and later a bronchitis started in the middle of November. These signs continued, not severe but persistent,—one day better, the next day worse until finally early in March it was evident the intestinal obstruction was becoming more marked. She was hospitalized and died March 20,—four months following the first signs of this illness. A post-mortem was obtained and is outlined here.

At the post-mortem, after special attention had been given to the cause of death, search was made for any pathological findings which could be attributed to the grippe-like symptoms and the sustained temperature of 103, going up to 106 on the day of her death. The blood count had been normal in every respect with a white count under 6000 on two occasions and a normal differential. The lower lobes of the lungs were bloody but this was attributed to chronic passive congestion; there was no pneumonia. The liver was enlarged and fatty; the intestines were distended and difficult to dissect due to multiple dense adhesions. There were multiple ulcerations in the descending colon which the pathologist said might be due to vitamin deficiency. There was a chronic inflammatory process in the rectum which was the cause of the obstruction. Nothing significant was found to explain the grippe-like symptoms. In the search for a disease which might cause a high fever with a normal white count blood had been obtained prior to death and examined for typhoid group and brucellosis. These were ruled out.

It has been mentioned at the outset of this paper that older people, those persons with hypertension, and those with chronic illness seem to fare less well than the healthy and more vigorous. One patient with a known hypertension of years, developed what seemed to be a common cold three weeks before stricken with a coronary occlusion. The cold had been unusually severe and persistent. On the third day of the coronary occlusion he developed a left paraplegia, unquestionably caused by an embolus. He is slowly recovering but in the three months following this episode there has been no cessation of symptoms attributable to this grippe syndrome.

Amongst the cases from which these data have been taken are over twelve patients under treatment today who are having sufficient of the above symptoms to warrant diagnosing this peculiar grippe syndrome. These cases have been under observation over a period of one month to two years. It is interesting to note the ability of these patients to tolerate this illness over a long period of time and maintain good general health.

Treatment is entirely empirical. Nothing except time seems to check the progress of the illness in those persons who seem to be more susceptible than the average. Once the diagnosis has been made one feels peculiarly safe, as even the most violently ill never seem to be at death's door.

It has been found that where severe vomiting and diarrhea are present in the gastro-enteric phase morphine grain $\frac{1}{6}$ or $\frac{1}{4}$ given hypodermically, and if hospitalized, intravenous fluids gives almost immediate relief. This, followed by milk of bismuth with paregoric and a soft diet for two days, with rest in bed during the acute stage, is sufficient for this phase. The rapid return to normal in these cases is striking. However, the more prolonged intestinal symptoms which often follow with spastic colon,

borborigmus, alternating loose and constipated stools, are harder to treat. These symptoms continue for months and unless one's patient has infinite faith he will go shopping from physician to physician or even turn to the cults. Occasionally the physician himself will have misgivings, and x-ray studies with stool examinations are resorted to as in the cases listed above. There is good reason to believe many of these have been operated for appendicitis where there was not sufficient pathology found to account for the severity of the symptoms. Nor does the leucocyte count help, as in these gastro-enteric cases the leucocyte count is elevated and the polymorphonuclear cells are relatively high. The acute gastro-enteric cases bear watching too, as occasionally just when the acute stage is over true appendicitis does develop, as happened in three of the author's cases, or acute cholecystitis such as the fatal case described above.

Salicylates in rather heavy dosage are the most valuable remedy for the symptoms of muscle, joint and fascial pains. Given in the enteric-coated tablets patients can continue their work and keep quite comfortable. When severe, as in some cases of low-back pain and sciatica and two cases of subdeltoid bursitis, bed rest, heat, liniments and sedatives were resorted to for a period of time. X-ray treament has not been tried but might help.

Sulfadiazine seems to be of no use except where secondary infection is playing a conspicuous part, especially in tonsillar, middle ear, laryngeal, bronchial, pulmonary, and possibly sinus involvement. In four cases where pyelitis developed in the course of this grippe syndrome sulfadiazine was used and seemed to benefit. A very mild fifth case cleared up just as promptly without any medication. Recently a desperately ill 72 year old rugged male who not only had the pyelitis phase but also pulmonic findings by x-ray, was given penicillin alone at first and later sulfadiazine. The temperature and symptoms gradually subsided during eight days, but there was lacking that dramatic effect we have been accustomed to see in cases where these drugs are specific.

The stomatitis, the conjunctivitis, the herpes, the angio-neurotic edema, and the many other symptoms that seem to accompany this symptom complex are treated the usual way.

It would seem that a true to type pattern of this illness cannot be made. In all probability until we know more about viruses the truth of what we are dealing with here will have to wait. It is conceivable that all this complexity of illness is caused by one active agent attacking hosts with varying susceptibilities, but it is barely possible also that more than one active agent is attacking an individual who has suddenly become susceptible for some reason to that group of active agents, be they virus or what. It would seem that in most individuals the upper respiratory tract was the most susceptible, or possibly the most accessible. At any rate the upper respiratory tract from beginning to end is the most involved. Next is the gastro-intestinal tract, next the lungs, then the muscles, joints, bursae, et cetera.

An interesting observation is the bunching of symptoms. Last September there were a great number of patients who reported with pain about the left shoulder, left chest and back of neck. In some tender points were discernible and enlarged tender lymph nodes found in the axillae, in the cervical region and along the intercostal spaces. In three of these herpes developed. All gave sufficient history to indicate that they had been suffering with this grippe syndrome. About Christmas time there were many cases of gastro-enteritis, some new and some already known to be suffering from this illness. Now recently there have been four cases of pyelitis, three of which were already being followed and treated for this syndrome; and the fourth,—a new case—has enough of the findings to make a tentative diagnosis. These four cases had no contact with one another.

As result of observations the question now arises: Do the cases where only one phase is evident belong to this syndrome? There were seven cases which are worth citing briefly and which brought out as if in emphasis one phase of this many symptom grippe. All other phases or symptoms were entirely absent or else so subordinated they did not enter the picture at first glance. However, a more careful workup or a longer period of observation has revealed one or two of the above listed symptoms in most of the seven cases.

One of the first of these cases was J. G. K., 61 years old; first seen after three days of vomiting. He was hospitalized and carefully studied. The gastro-enteritis which lasted over three weeks seemed at first to be the whole story but there was evidence of an upper respiratory infection including an inflamed left ear drum. A chest x-ray revealed consolidation of the right lower lobe. He had no cough; respirations and pulse were slow and he did not complain of pain. Without the x-ray this pneumonia

could have been missed. Also another significant symptom which was brought out at the height of his illness was mental confusion and forgetfulness observed in many of these cases.

Two cases stressed the low-back pain and sciatica of this symptom complex. One, S. R., a man 60 years old, was not under close observation. His disability lasted six months. A search for other of these symptoms in his history uncovered the following: recurring colds, diarrhea, bloodshot eyes, vertigo, weakness, pains in various joints, and headaches. The second of these two cases, S. McB., a woman of 65 years, had an even longer disability due to low-back pain and sciatica. She was more carefully followed and was noted to have the persistent upper respiratory infection starting two months before the main condition. When hospitalized, x-ray examination showed an old osteo-arthritis of the sacro-iliac joints. The upper respiratory infection persisted and four months after onset of the low-back pain and sciatica she had a very short episode of gastro-enteritis with vomiting and diarrhea. At the end of eight months the entire condition had cleared up.

A case that could exemplify the entero-colitis phase was J. B., a man 59 years old, who lost 30 pounds in two months in the spring of 1943 when he suddenly developed diarrhea that would not yield to any treatment. Hospitalized twice and carefully studied from every angle, no known cause could be found. One internationally known clinic called the condition "Non-Tropical Sprue" and put him on roughage-free diet and large doses of vitamins. After eighteen months of illness his symptoms subsided but he still follows a very careful diet. The only hint in the course of his illness that might tie this case in with this complex was a period of extreme dizziness, mild upper respiratory infection and very foul breath.

The fifth case under discussion could exemplify the angio-neurotic edema and urticaria of this complex. A. P., a woman of 41 years, had been under treatment for sore throat and arthritis following an automobile accident in the fall of 1943. In February, 1944, ulcers of the mouth developed and gradually healed. Thereafter the angio-neurotic edema developed with very severe general symptoms of weakness, anxiety, and formication. The edema was restricted to the face, left arm, left thigh and left leg. Later, she was studied in a clinic and her condition was diagnosed as "Menopausal." However, there was spastic colitis, and persistent upper respiratory infection and the administration of female sex hormones did not help. A neuro-allergic dermatitis developed later which is closely allied to the angio-neurotic edema. Beside the spastic colitis there was a period of dizziness, the arthritis and stomatitis to suggest this case could belong to the complex under discussion. The mental symptoms in this case made two of the observers feel that they were dealing with a psychosis or at least a psychopathic personality. Non specific vaccine therapy decreased her symptoms, and she is improving but is still far from well.

One of the earliest cases observed was an extremely severe virus pneumonia in July, 1942. All we thought of at that time was the pneumonia. Observation of these other cases since has brought up the question: should this case be classified as a member of this symptom complex? D. O., an eight year old boy with a healthy past history was hospitalized for six weeks and in an oxygen tent about three and a half weeks. He had the classical virus pneumonia together with hepatomegaly and splenomegaly of marked degree. Convalescence was slow. In reviewing this case nothing suggests a definite answer to the above question. Home from the hospital he continued to have symptoms of respiratory difficulty and a definite fresh bronchitis in November. His tonsils and adenoids were removed in December in an interval of relative freedom from upper respiratory infection. In February 1943, during a checkup physical examination, he was found to still have marked inflammation of the upper passages. In March he had what was diagnosed as German measles, followed in a few days by an enterocolitis and bronchitis with severe vomiting and diarrhea. Since then he has gone along smoothly and is a fine healthy and normally growing boy.

This last winter there have been two cases of hemoptysis starting with brisk bleeding, gradually subsiding over a long period of time. One of these, V. K., a young woman war industry worker, has lost three and a half months' work with cough, wheezing and hemoptysis. She has been studied by x-ray and carefully reviewed by the State Chest Clinic, the latter reporting "An acute pneumonitis or atypical primary pneumonia," in which "tuberculous infection cannot be excluded entirely at this time." Nevertheless when she was at the height of her illness, she had vertigo and diarrhea with slight nausea but no vomiting. She has gained four pounds although she is still ill. Frequent sputum examinations have been negative for T.B. Time only will

answer these puzzling questions as to the part played by virus infection in certain of these frequently encountered illnesses.

In summary, this is a brief description of a very tenacious grippe-like symptom complex probably caused by a virus, the first suggestive cases of which were noted less than ten years ago. There are here reviewed a group of definitely connected symptoms and pathological states. There are also reviewed associated symptoms and pathological states less definitely connected but certainly part of the symptom complex. One case is cited briefly, and also the clinical findings during hospitalization in this and a few other cases. The pertinent data of one incidental post-mortem examination is reviewed. A brief outline of suggestive empiric treatment is given and comment on seven cases which may or may not belong to this symptom complex.

# DIAGNOSIS AND TREATMENT OF UTERINE AND PELVIC ENDOMETRIOSIS

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FOR THE purpose of this brief review, endometriosis is defined as that lesion in which tissue, histologically resembling the normal uterine mucosa, is found aberrantly within the uterine musculature, or at various points within the peritoneal cavity. Whether within the myometrium or the peritoneal cavity, such aberrant areas of endometrial tissue are under the influence of the ovarian secretion and the response of each to this secretion brings about changes similar to those which occur in the normally situated uterine mucosa. In other words, these endometrial implants resemble miniature uterine cavities, and it is their hormonal response to the ovaries which, in part at least, accounts for the symptoms characterizing the lesion.

The presence of ectopic endometrium within the wall of the uterus is explained by an unusual growth activity of the normally placed endometrium, which pushes its way outward from the uterine cavity into the surrounding muscle. Associated with this endometrial invasion there is generally a diffuse myometrial overgrowth. However, the enlargement of the organ never attains that of the myomatous uterus nor are secondary nodules commonly present.

Clinically, the weight of the enlarged uterus may be associated with a sense of pelvic pressure and backache, but the outstanding symptoms are excessive menstruation and dysmenorrhea. The latter is of a colicky nature and is due to the contractions of the uterus resulting from the menstrual swellings of the intramural endometrial islands. When, in addition, endometrial implants in the pelvis involve the utero-sacral ligaments, the menstrual swelling in this region produces pain referred to the rectum.

In many cases the exact diagnosis is not made until the tissues are examined microscopically. However, the following findings are most suggestive of the endometrial lesion:

1. A moderately and diffusely enlarged uterus firmly fixed in the pelvis.

2. Small nodules palpable in the region of the uterosacral ligaments.

3. Excessive menstruation.

4. Colicky dysmenorrhea referred to the rectum or lower sacral or coccygeal regions.

The treatment of the lesion is surgical. In women nearing the end of the reproductive period hysterectomy is indicated. If there is associated ovarian disease, or if there is any other evidence of endometriosis, a bilteral salpingo-oophorectomy should also be done. In younger women a more conservative operation is indicated and the ovaries, if possible, should be conserved.

The conditions found at operation upon a patient with pelvic endometriosis differ according to the extent of the lesion. Occasionally the uterus and ovaries appear normal, although implants may be scattered throughout the pelvic cavity. In the usual case there is found in the ovarian region a cystic

*Presented at The New Haven Medical Association, April 18, 1945*

mass which is likely to be densely adherent to the posterior surface of the uterus and to the posterior leaf of the broad ligament. If implants are present at other points in the pelvis, one sees puckered hemorrhagic areas which are generally dark bluish in color. In other instances in which the ovaries appear at first to be normal, more careful inspection reveals reddish-blue puckered points which represent tiny endometrial implants. Likewise, the uterosacral and the round ligaments and the rectovaginal septum may show evidences of endometrial invasion. In more extreme cases the uterus and ovarian cysts are densely adherent and there is an extensive invasion of the rectal or sigmoid wall. In one of our patients the involvement of the pelvic tissues was so diffuse as eventually to bring about a complete obstruction of both ureters, necessitating bilateral drainage of the kidneys.

In connection with the character of the ovarian cysts which are sometimes found, it should be pointed out that the diagnosis of a true endometrial cyst depends upon the presence in the cyst wall of tissue having the histological characteristics of uterine endometrium. The cystic content of a chocolate colored fluid is not necessarily pathognomonic, since other types of cyst, for example a follicular or a corpus luteum cyst or a cystadenoma into which bleeding has occurred, may likewise contain a chocolate colored fluid, though no trace of tissue resembling endometrium is present. To put it in another way, large ovarian cysts which contain a chocolate colored fluid are almost certainly not of endometrial origin, for true cystic structures of the latter type are commonly not larger than an orange.

Recently we have had under observation a patient who presents endometrial implants in a more uncommon site, the vagina. These implants, which have been evident for several years, are seated beneath the mucosa of the posterior vaginal wall, and are recognized grossly by their bluish-red appearance. A histological study of one of these excised lesions shows a superficial covering of normal vaginal mucosa beneath which is a small cyst containing blood and lined by cells and stroma indistinguishable from normal uterine endometrium. Laparotomy has failed to show any corresponding pelvic involvement and the source of origin of the vaginal islands is still unsettled. Excepting a slight occasional oozing, these vaginal implants are asymptomatic.

Dr. Fiorito has recently informed me of a case similar to the one just mentioned in which, coincident with gestation, the vaginal implants have become definitely more prominent. Without doubt this enlargement depends upon a decidual reaction such as is known to occur in endometrial implants in association with pregnancy.

Vesical endometriosis, which occurs only rarely, is thought to be secondary to a pelvic endometriosis which has extended from an affected pelvic structure into the bladder. A similar explanation is offered in those unusual instances in which an endometrial structure forms a definite tumor within the wall of the ureter.

Pelvic endometriosis, while occasionally seen in women in their late twenties, is most often met in women who have reached the third decade. Although menstrual disturbances may be present, there may be no characteristic symptoms. Some patients complain of pain which begins from 2 to 10 days previous to the onset of the menstrual flow. In those in whom there is an involvement of the uterosacral region there is likely to be pain referred to the sacral or coccygeal regions. In some there is an associated menorrhagia but this, in our experience, is unusual. When bleeding is excessive one suspects that a myoma may be present in addition to the endometrial lesion. In some patients the picture strongly resembles the common type of pelvic inflammatory disease.

Since there may be no characteristic symptoms, it often happens that the correct diagnosis of pelvic endometriosis is not made until a laparotomy is done. Perhaps the most suggestive findings upon pelvic examination, in the usual case, are a palpable thickening of the uterosacral ligaments and the presence of small, hard nodules elsewhere in the pelvis. Small bluish-red cysts, shining through the vaginal mucosa posterior to the cervix, are always particularly suggestive of a pelvic lesion of this type.

In connection with the problem of diagnosis it should be noted that in the most severe cases, where the pelvic structures are extensively involved, the fixity of the cervix, the uterine body, and the adnexae, together with parametrial thickening, will probably suggest the possibility of a well advanced pelvic malignancy.

The treatment of pelvic endometriosis is complicated by the fact previously mentioned that the aberrantly situated endometrium reacts in the same way to ovarian hormones as does the endometrium of the uterus. In other words, the growth and development of each individual implant is influenced

by the internal secretion of the ovaries and each implant is believed to remain active just so long as functioning ovaries are retained within the body.

In the woman who has had numerous children and whose reproductive activity is drawing to a close, the excision of the ovaries is of less significance than in the younger individual. Consequently, in patients of the 4th or 5th decade whose pelvic organs are extensively involved by a lesion of this type, a radical operation is justified. This commonly includes a hysterectomy and bilateral salpingo-oophorectomy. No attempt is made to excise the individual implants which may be scattered over the pelvic peritoneum since, with the ablation of both ovaries, the stimulating hormonic influence ceases and the implants become inactive and symptomless.

If the patient is a young woman the solution of the problem is not so simple, for under these circumstances one wishes to follow as conservative a course as possible. When in such a patient only one ovary is involved by the endometrial lesion, this organ is excised but the other undisturbed. Since the uterus is left in situ, it may still be possible for a normal pregnancy to occur and to progress to term before there is a recurrence of pelvic symptoms. In some patients a conservative operation of this sort may give complete relief; in others, rather insignificant symptoms persist; in a third group, subsequent laparotomy with the excision of the remaining pelvic structures may eventually be indicated. There is a tendency to adopt in young women a more conservative attitude toward pelvic endometriosis than was formerly the case. Indeed, some clinicians feel that even in the presence of multiple pelvic implants, the removal of the uterus alone is adequate for the relief of symptoms. Whether so conservative a method of treatment will always permanently cur the patient is at the moment open to question.

Rarely, a young patient is seen whose pelvic struc tures are firmly fixed by an extensive endometriosis In addition, premenstrual pain may have been s severe and prolonged that repeated doses of morphi may have been necessary to control it. In such case, hysterectomy with the removal of both ovarie is held as the only guarantee of relief and seem clearly justified.

When the bowel wall and the rectovaginal septun are involved, it is impossible to remove each indi vidual implant. In the presence of such findings resection of the rectum has been done. So extensiv an operation seems not fully justified, since the re moval of both ovaries is commonly followed by regression of the endometrial areas and a relief o symptoms.

For several reasons the use of radium or of roent gen rays as a primary method of treatment of endo metriosis is not generally advisable. On the othe hand, judicious postoperative rotengenotherapy may be helpful in certain patients in whom the pelvi pathology has been so extensive as to prevent th complete excision of ovarian tissue at laparotomy.

Finally, the question arises respecting the advis ability of using estrogenic therapy in those women who present themselves with menopausal symptom subsequent to the ablation of both ovaries for th cure of pelvic endometriosis. While such therapy may be necessary, it is better avoided if possible; fo certain authorities hold that the prolonged use o estrogens in such patients may reactivate any im plants which have been incompletely removed a laparotomy, and thus lead to a recurrence of som of the symptoms originally present.

# A CASE OF INCARCERATED UTERUS SUCCESSFULLY TREATED IN 1808

HERBERT THOMS, M.D., *New Haven*

INCARCERATION of the pregnant uterus is not a common complication of pregnancy. When present it can usually be successfully treated by modern methods even if laparotomy has to be resorted to. However, previous to our time, before the development of aseptic techniques, the successful treatment occasionally offered many difficulties. In reviewing the present case we are reminded of another instance in the annals of medical history the significance of which was truly great. This was the celebrated case of Mrs. Merrill of Montgomery, Alabama, who was successfully treated by Dr. J. Marion Sims. It will be recalled that the invention of the Sims speculum and the development of a cure for vesicovaginal fistula were the direct result of Sims' experience, and when we consider his eminent and spectacular career from that time forward, we are inclined to hazard a view that Mrs. Merrill ought also to have her niche, even if a small one, beside her famous compatriot Jane Crawford.

The case here reprinted is interesting from two points of view: first, because of its early record and, second, because of the method used in its successful treatment. It was apparently the author's wish to remain anonymous, for he chose to sign his contribution, "A Member of the Society," and a cursory search has not revealed his identity. He remains, therefore, as he wished it, unknown. The story begins in the year 1809, when, at a Convention of the Fellows of the Medical Society of the State of Connecticut a committee was appointed to select pieces for publication from such communications as were then in the possession of the Secretary and publish them before the meeting of the next convention. The result was the publication in 1810 of a collection of fourteen papers, all of which were signed except the one referred to here. Among the authors we find names notable in American medicine. Lemuel Hopkins, a pioneer in the treatment of tuberculosis and a "Connecticut Wit," Eli Ives, a founder and professor of the Yale Medical School and one time President of the American Medical Association, and William Tully, "unrivaled in his knowledge of the materia medica" and important as a medical educator. The final item in the Table of Contents is a Case of Retroverted Uterus and appears as follows in the text:

"*The following case of retroverted Uterus may be important, on account of the simple means used to restore the Uterus.*

"September 23, 1808, Mrs. A—— of New Haven, a woman of forty years of age, the mother of eight children, in jumping from a horse, felt something give way in the pelvis; at this time she supposed herself to be about three months advanced in pregnancy. The shock was followed by great weakness; sensation of bearing down, costiveness, dysuria, nausea, and vomiting, and all the train of hysteric symptoms, arising from the stomach, sympathizing with an irritating and inflamed uterus. These symptoms were supposed by the patient to arise from her pregnancy, and of course were endured with patience, until they increased to a very alarming degree. A period of fifteen days elapsed, during which she took a little castor, valerian, etc. At this time she was examined. Entering the vagina, the finger met a tumor twice the size of a hen's egg, between the vagina and rectum, pressing itself forward into the vagina, and occupying two-thirds of the os externum. A finger of the other hand was passed into the rectum, by which it appeared that this tumor was a sack of the rectum filled with indurated feces, which sack had been formed by the pressure of the superincumbent uterus; passing the finger into the rectum, a little farther up, the rectum was entirely obstructed by the fundus of the uterus, beyond which the finger could not pass, and on which it could make no impression. The uterus at the same time was felt by the finger in the vagina, wedged firmly between the sacrum and pubis and the os tincae, in the superior and anterior parts of the vagina. At this time the stomach could retain nothing—strong spasms agitated the system frequently; bowels were full and tense, particularly above the pubis; frequent inclination to pass urine and stool, with much pain and distension in the

*Reprinted by permission from American Journal of Obstetrics and Gynecology, April, 1944*

pubis. The urine had been entirely obstructed; but for two or three days past the patient thought she had passed the usual quantity of urine; however, the catheter was introduced, and eight pounds and three ounces of urine drawn off. The rectum was also emptied. The patient was laid upon her back, her hips raised; in this position, with two fingers in the vagina, and two in the rectum, exertions were made to restore the uterus, until her physicians were satisfied that it could not be restored in this manner. The patient was placed on her knees and elbows, and repeated trials made to restore the uterus, but with no better success. The uterus was finally restored by an instrument resembling a probang, made of a cylinder, the size of the finger, and eighth or ten inches in length, on the end of which a head was formed, by winding flax and covering it with soft leather, as large as could be passed into the rectum. With this instrument, oiled and introduced into the rectum, the patient on her knees, the thorax lower than the pelvis, two fingers in the vagina, and much force applied by the instrument and fingers, the uterus was raised above the brim of the pelvis. The patient was enjoined rest and a recumbent posture; and after the usual period of gestation, was delivered of a healthy child.

"A Member of the Society.

"New Haven, July 10, 1810."

In the above case it will be seen that the author first used without effect the technique later successfully applied by Sims. It remained, therefore, for him to exercise an ingenuity which he probably came by through his Yankee forbears.

# CONNECTICUT MEDICINE

In an attempt to convince the people of the United States that Federal aid is necessary if maternal and infant mortality is to be kept at a low level, Senator Pepper cited statistics showing the remarkably low rate in the State of Connecticut. To those outside our boundaries, it might be assumed that the results attained were related in some manner to Federal aid. Such is not the case.

Connecticut stands out because of the quality of medical care administered by competent physicians cooperating at all times with a most efficient State Health Department. The people of Connecticut can justifiably object to assuming part of the burden of Federal taxation for improvement of medical care in some inefficient State. There is no secret to our success. Those interested are welcome to come to Connecticut to learn that it is not regimentation which accounts for the results, but just plain New England initiative and common sense.

Connecticut leadership is demonstrated in our program for closer cooperation with the Veterans Administration to assure prompt and efficient medical care for returning Veterans. The plans are developing rapidly under the guidance of an active committee of your State Society.

Physicians of Connecticut always respond when called upon. This is so evident in our request for donations for a permanent home for the Connecticut State Medical Society. The returns have been most encouraging. Every physician in the State should feel proud that he has contributed to the betterment of medical service through his State Society. If you have neglected to do your part, surely it is through forgetfulness. Why not mail your check today?

Joseph H. Howard, M.D.,
*President, Connecticut State Medical Society*

# SEMI-ANNUAL COUNTY ASSOCIATION MEETINGS

## Fairfield, Wednesday, October 3

Ridgewood Country Club, Danbury

Business session 4:30 P. M. Dinner 6:30 P. M.

*Speaker:* B. Reynolds Reiter, M.D., recently returned from three years as chief surgeon in the European Theatre of Operation

*Subject:* WAR SURGERY

## Hartford, Tuesday, October 23

Hunt Memorial Building and Hartford Club, Hartford

Business session 4:30 P. M. Dinner 6:30 P. M.

*Speaker:* Major W. H. Lowell, MC—AUS, of Hartford

*Subject:* SOME OBSERVATIONS IN THE CHINA-BURMA-INDIA THEATRE

## Litchfield, Tuesday, October 2

Maggi Company, Inc., New Milford

Luncheon 1:00 P. M. Entertainment by host 2:00 P. M.

Business meeting 3:00 P. M. Social hour 4:00 P. M.

## Middlesex, Thursday, October 11

Edgewood Country Club, Cromwell

Business meeting 4:30 P. M. Scientific program 5:30 P. M.

*Speaker:* Lieutenant Colonel James C. Fox, Jr., MC—AUS

*Subject:* REMINISCENCES OF OVERSEAS SERVICE WITH THE 39TH GENERAL HOSPITAL

Dinner 7:00 P. M.

The Middlesex Woman's Auxiliary will meet with the Middlesex County Medical Association.

## New Haven, Thursday, October 25

Waterbury Country Club

Business Meeting 4:00 P. M.

*Round Table Discussion:* "PREPAYMENT MEDICAL SERVICE"

*Speakers:* Mr. Wallace E. Campbell, Hartford; Dr. Creighton Barker, New Haven; Dr. James R. Miller, Hartford; Dr. J. Harold Root, Waterbury

*After Dinner Speaker:* Dr. C. C. Burlingame, Hartford

*Subject:* PSYCHO-NEUROSES OF THE RETURNING SOLDIER

## New London, Thursday, October 4

Uncas-on-Thames, Norwich

Business meeting 4:30 P. M. Dinner 6:30 P. M.

Scientific meeting 8:30 P. M.

*Speaker:* J. R. Paul, M.D., Professor of Preventive Medicine, Yale University

*Subject:* POLIOMYELITIS

## Tolland, Tuesday, October 16

Old Homestead Inn, Somers

Dinner 6:30 P. M. Business Meeting 7:30 P. M.

*Speaker:* Frederick S. Ellison, M.D.

*Subject:* PRACTICAL PROBLEMS IN DISEASES OF THE RECTUM AND ANUS

## Windham, Thursday, October 18

Putnam Country Club, Putnam

Dinner and Business Meeting 12:30 P. M.

Speaker and subject to be announced

## A. M. A. HOUSE OF DELEGATES TO MEET DECEMBER 3 TO 6

ARRANGEMENTS HAVE BEEN MADE TO HOLD THE 1945 MEETING OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION IN CHICAGO, DECEMBER 3 TO 6, INCLUSIVE. THIS WILL REPLACE THE MEETING USUALLY HELD IN JUNE AND POSTPONED BECAUSE OF O.D.T. REGULATIONS. THE REGULAR SCIENTIFIC SESSION FOF 1945 HAS BEEN OMITTED.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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Footnotes, bibliographies and legends for cuts should be typed on separate sheets in double space similar to the style for the text matter. Bibliographies should conform to the style of the Quarterly Cumulative Index published by the American Medical Association. This requires in the order given: Name of author, title of article, name of periodical with volume, page, month—day of month if weekly—and year.

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NEWS: Our readers are requested to send in items of news, also *marked* copies of newspapers containing matter of interest to physicians. We shall be glad to know the name of the sender in every instance.

ADVERTISEMENTS: All advertising copy of products approved by the Councils of the American Medical Association shall be acceptable for publication, together with advertising copy of products exempted by these same Councils, provided such copy does not present a product in a false and/or misleading light. Such other advertising copy may be accepted, subject to the approval of The Editorial Board. All copy must reach the JOURNAL office by the 10th of the month preceding publication.

SUBSCRIPTIONS: Membership in the Connecticut State Medical Society includes subscription to the JOURNAL. Additional copies may be secured from the Editor.

REPRINTS: Order blanks for reprints will be sent to each author with the galley proof of his manuscript. Reprint orders should be returned at once as the type will be destroyed within one month following publication of the manuscript.

# EDITORIALS

## Unanimity and Friendship

On the fifth day of January in the year 1784 the physicians of New Haven County met at the Coffee House on New Haven Green to found the Medical Society of New Haven County. The first purpose of the new society was "To lay a proper foundation for the Unanimity and Friendship which are essential to the Dignity and Usefulness of the Profession." These lofty words were not different in essence from those expressed by the founders of the other county associations which later became integrated into the State Medical Society and they echo a feeling which was shared by most thinking men at a time momentous in American history. Following the defeat of the common enemy in 1782 this country entered into the "critical period" of government under the Articles of Confederation and then as now were seen evidences of great social dislocation and a general apprehension as to the uncertainties of the future. Fortunately, the political leaders of that day recognized these very grave dangers and formed the Constitution which brought together the discordant forces and amalgamated a great nation.

The analogy between these uncertain times and our own does not need to be particularized. It is obvious that today our profession faces not only the general uncertainties of civilization but also those concerning its own position as a useful group within that structure. Truly the emergency of peace brings its challenge to Medicine with no less directness than the emergency of war and they are blind indeed who do not recognize that the forces of social innovation are being now clearly directed at the social aspects of medical practice.

When we consider what has happened in the recent British election and its certain impact on medical practice in Great Britain it must be realized that the hands of those who advocate certain governmental controls of medicine in this country have been considerably strengthened. It is certain that if

the medical profession is to maintain a sound position in our own society it will have to unite not only as did our forefathers in bonds of unanimity and friendship but it will have to state its objectives and fight with singleness of purpose for them. Nowhere have these objectives been better or more clearly stated than in the recent words of Dr. Wilson G. Smillie of Cornell University Medical College who writes, "It would seem to be more appropriate, in planning for the development of a nation-wide program for medical care, to utilize the genius of American people for local self-government, to employ the enormous latent forces of voluntary cooperative enterprise, to develop a medical care program slowly and progressively on a local community basis, building on the sound foundation of local community autonomy, with state guidance, and with state assistance when necessary; and with federal encouragement by subsidy to those communities in greatest need." The words of this fine statement will fall pleasantly on the ears of Connecticut physicians who do not forget the great part played by their State in the formation of our national governmental structure under the fundamental principles of local self government. In order for Medicine to further such a sound program it would do well to remember this can be done best if it seeks to develop within itself those "essentials to the Dignity and Usefulness of the Profession, Unanimity and Friendship."

## Hospitals and Doctors Review Blue Cross Plans

Dr. L. Henry Garland, who writes for this JOURNAL on the above subject, points out that because of the rapid growth of hospital service insurance plans, the time has come for the profession and the hospitals to review experiences and define their basic fields of public service. To this end he recommends that the medical profession should be adequately represented in hospital groups along with those of the public and hospitals. Dr. Garland's words of wisdom and plain speaking come to us at an opportune time, for the issues which he considers are precisely those which are confronting the profession in Connecticut at this moment. Now, if ever, we must insist that a clear distinction be made between hospital services and medical services if the public is to be efficiently and properly served. His concluding words also carry a significance which should be remembered, particularly by those planners who, in ideological pretense, often speak of medical service in terms suggesting those applied to a commercial commodity. "In the final analysis it is the medical profession which transforms a building from just a hotel or a pest house into a living institution for the healing of the sick, a modern hospital."

## Cancer Death Rate Improving

The mortality from cancer, particularly among women, is beginning to come under control. This is indicated by the experience among the many millions of industrial policyholders of the Metropolitan Life Insurance Company and is confirmed by other sources. In the past decade, for example, the age adjusted death rate from cancer among insured white females dropped 11 per cent at ages 1 to 74 years; virtually every important age group shared in the improvement. The current mortality from the disease among women in the broad age range 35 to 64 is the lowest in a third of a century, having dropped by one-fifth during that period.

Among white male policyholders, too, a favorable indication is noted. The distinctly upward trend which had been manifested for many years has been stemmed. In fact, during the past decade, at no age beyond 25 years has the cancer death rate among these men shown any increase, and at some age periods the mortality has tended downward recently.

That the organized movement to control cancer is bearing fruit is evident from the fact that people, and more especially women, are seeking diagnosis and treatment earlier in the course of the disease, when the chances of cure are best. For example, among the patients at the cancer clinics in Massachusetts, the average delay between first symptoms and visit to physician was reduced from somewhat more than six months in the period 1927 to 1935, to 3.3 months in 1943.

To give further impetus to this movement, the Metropolitan Life Insurance Company is conducting a special campaign during October. At that time, the Company's more than 20,000 field representatives, in cooperation in many communities with official and voluntary agencies, will distribute to practicing physicians a special packet of new information on cancer. Included will be the American Cancer Society's booklet, "The General Practitioner and the Cancer Patient;" a reprint of recent studies of cancer mortality prepared by the statisticians of the Metropolitan; a reproduction of the Company's educational advertisement on cancer, "Cancer Has

Its Hopeful Side!," appearing during October in national magazines with a combined circulation of about 30,000,000 readers; and a copy of the Company's new leaflet for laymen, "There is Something *You* Can Do About Cancer." As part of this "message of hope about cancer," Metropolitan Field Representatives will endeavor to place the latter publication in more than one million homes. In addition, these representatives will place in prominent locations in their communities 6,000 window cards urging early diagnosis of cancer.

## The End of Censorship

At last in this country we are free from the blackout of censorship. The average reader of a medical journal has probably given little thought if any to the restrictions of censorship under which its editors have worked during the recent war. If the functions of censorship and of government war information had been combined again as they were during the first World War under the Creel Committee on Public Information, or if a less realistic boss censor then Byron Price had been at the helm, we might have experienced a much more difficult time. To Mr. Price, the experienced executive news editor of the Associated Press, should go an expression of appreciation from all editors of State medical journals. Because he knew the value of the fullest information consistent with the overriding demands of military security, he has been able to obtain in most instances a degree of support which has been almost phenomenal. For the most part he fought the overzealous, self appointed censors of the armed services and the civilian government. According to the editor of one of Connecticut's well known dailies, on at least one occasion he even prodded editors into fuller publication of the facts, asking them to help him see to it that "a dangerous psychology of overcensorship is not created throughout the land by the acitivities of a miscellany of volunteer firemen."

The experiences of the Connecticut State Medical Journal with Mr. Price and his censorship regulations have been most happy. On but one occasion was this publication reprimanded for submitting details which were contrary to rules. This instance was due to an oversight on the part of a busy editor, was recognized as such, and nothing further was said or done. It is most gratifying in this day of Federal bureaucracy and seemingly attempted regimentation against the medical profession to be able to write finis to a program such as this one with a feeling of genuine appreciation.

## Overcrowding of Hospitals Under Blue Cross Plans

Many who have viewed with concern the rapid expansion of Blue Cross Hospitalization Plans and its effect on hospital bed occupancy will await with interest the report of an investigation of hospitalization in Michigan.

The Michigan Legislature, before adjourning its regular biennial session, decided to investigate the effect of non profit hospital service plans in overcrowded hospitals in the state's industrial centers to the point where persons acutely needing hospitalization could not be accommodated. Senator Blondy of Detroit, who called attention to this alleged condition and offered a resolution providing for an inquiry, was named chairman of a three member committee to conduct the probe.

The Eastern Underwriter quotes Mr. Blondy as saying, "Persons holding the so-called service contracts, virtually all issued by Michigan Hospital Service, have insisted on collecting their policies for minor complaints and hospitals subsequently have become crowded to the extent that serious cases have been rejected."

Senator Blondy contends that many patients receiving treatment under hospitalization insurance should have been treated in their home rather than occupying hospital beds but insisted on hospitalization because they could not otherwise collect benefits.

## China Friendship Day

October 10, 1945 will mark the thirty-fourth anniversary of the Republic of China. The founding of the republic in 1911 was largely due to the leadership of Sun Yat-sen, the famed revolutionist and "father of his country." The liberation of China from the corrupt Manchu conquerors changed the destiny of a quarter of the earth's people.

Sun Yat-sen was the first graduate of the new British Medical College which had opened in Hongkong in 1885. In 1911, while Dr. Sun was in the United States, he learned of the successful overthrow of the Manchu government and a month later, while in London, he received an invitation to head the new government of China.

Dr. Sun's program for a free and modern nation has been delayed by civil wars and then by the Japanese invasion and occupation. During the recent war the International Peace Hospitals have served more than 52,000,000 Chinese civilians and guerillas who have turned every inch of "occupied" territory into war areas. The four base hospitals have a total of 4,000 beds. One of these was housed in bombproof caves in Yenan, Shensi Province. Three others were in scattered huts behind the enemy lines. In schools attached to the hospitals more than 700 students trained to become doctors, nurses and first aid workers. They lived in caves and attended classes out-of-doors and more than one-fourth of them were women. Mobile medical units and physicians mounted on horseback followed guerillas and carried equipment for operations, dressings and prescriptions. For more than three years no supplies of Western drugs or equipment reached the International Peace Hospitals. Funds from America made it possible to manufacture some supplies locally and others have been smuggled through enemy lines. Physicians often have had to perform operations with crude handmade instruments and without anesthetics. Bamboo pincers and wood retractors are among the makeshifts which have been in use. Equipped with primitive hand machinery, two drug cooperatives have been manufacturing Chinese medicines from native herbs and preparing vaseline from locally refined oil.

Thus has China carried on!

## HOSPITAL INTERNSHIPS

*Editor's Note: At the request of the Executive Secretary the hospitals in Connecticut which offer intern service have been asked to furnish a statement regarding such service. These will be published as they are received, the second installment of which appears herewith.*

### NORWALK GENERAL HOSPITAL

INFORMATION FOR APPLICANTS FOR INTERNSHIP

*Hospital:* 257 beds, including 44 bassinets. Population of town 45,000; of area served, 75,000. Annual admissions about 6,500 covering a broad cross section of medicine, surgery, obstetrics, pediatrics, and other common branches of medicine. Approved by the American College of Surgeons and for internship by the A. M. A.; member of the American Hospital Association; Nurses' Training School with 90 or more U. S. Cadet Nurses. Forty-two miles from New York City; one hour from Grand Central Station.

*Internship:* Mixed. The services consist of (1) Male medicine and surgery; (2) Female medicine and surgery, including gynecology and emergency room; (3) Pediatrics and obstetrics, including prenatal clinic; (4) Pathology, x-ray, pharmacy, physiotherapy and tumor clinic.

*Intern Staff:* Four interns and one resident. (This is a restricted, wartime staff.)

*Teaching:* Limited amount of didactic teaching by attending staff; good supervision and instruction by well qualified resident; excellent opportunity for practical work. Service patients largely cared for by the interns, under supervision.

(1) Monday's rounds are made with a visiting neurologist.

(2) Tuesday is tumor clinic, described below.

(3) Wednesday one intern attends a cardiology conference out of town. Transportation for this is furnished by the hospital.

(4) Wednesday noon is devoted to a lunchtime discussion of pertinent medical and surgical problems. Discussion is led by a member of the regular or visiting staff—selected by the resident.

(5) Alternate weeks the heads of the various departments make ward rounds which the interns are required to attend.

(6) Once monthly there is a Clinical-Pathological Conference presided over by the hospital staff.

(7) Once monthly there is a staff conference to which an outstanding medical or surgical authority is invited as guest speaker. Living hospital cases are presented by the interns and discussed by the speaker.

(8) Once monthly there is a meeting and dinner of the Norwalk Medical Society to which an outstanding speaker is invited to speak upon a chosen medical or surgical subject. These conferences are held in the evenings and interns not on duty are expected to attend. They are always highly instructive and interesting.

(9) Every day there is excellent bedside and operating room teaching by the attending staff.

(10) The hospital is visited often by outstanding authorities in all branches of medicine and surgery who come here as consultants.

*Laboratory:* Part time pathologist and laboratory personnel of eight. Interns do only emergency night laboratory work. Autopsy percentage about 25 per cent.

*Library:* New lounge; conveniently located and well supplied with both current books and journals. New books added as seems necessary.

*Salary:* Interns receive $100 per month and maintenance. No expense to intern in connection with the services he renders.

*Free Time:* Interns have three evenings off a week and every other weekend from noon Saturday until Monday morning, subject to such emergencies as may occur during wartime conditions.

*Recreation:* Moderate facilities are provided at the hospital and free membership including gymnasium and swimming privileges at the Y. M. C. A. two blocks distant. Tennis court on hospital property.

*Food:* Separate dining room for intern staff, with well varied and balanced food.

*Outpatient Service:* Weekly tumor clinic under personal supervision of two attendings from Memorial Hospital, New York. Referred cases are studied, presented and followed either as outpatients or hospital admissions. Prenatal clinic weekly. Patients are cared for, under supervision, followed throughout their pregnancy, delivered, and followed postpartum by the intern on obstetrical service. Dressing clinic to which selected cases treated in the Emergency Room and discharged surgical service cases return for follow-up treatment.

*Emergency Service:* Two ambulances averaging three calls per day. Emergency room admissions averaging six cases or more per day.

*Schools Represented by Interns:* The Intern Staff has represented many schools, including Cornell University Medical College, Columbia University College of Physicians and Surgeons, Long Island College of Medicine, Tufts College, Boston University School of Medicine, Medical College of Virginia, Western Reserve.

*Applications for Internship:* A formal application form is attached to be completed and submitted by the candidate, *together with a recent photograph* and at least three references. Following investigation by the Internship Committee, candidates will be interviewed if they can conveniently make a trip to Norwalk.

*General:* The hospital is interested in attracting well trained graduates of approved medical schools. The internships available are attractive to medical students who desire well rounded service and training, or to those who wish such an internship as a preliminary to further specialized training. A spirit of self reliance, responsibility and competency is fostered.

Interns who have recently served the hospital have expressed satisfaction with the service which they found to be a busy and practical one, lending a good grasp of the fundamentals of medicine and its allied branches.

Robert N. Brough, Superintendent

## THE LAWRENCE AND MEMORIAL ASSOCIATED HOSPITALS, NEW LONDON

The Lawrence and Memorial Associated Hospitals offers 4 rotating internships of one year's duration to qualified graduates of Class A Medical Schools. Appointment are made on the basis of recommendations.

The hospital has 349 beds, including 35 beds devoted to contagious diseases. During the past year there were 7,169 discharges divided as follows: medical 927, surgical 1,873 (including 518 ENT), obstetrics 2,006, newborn 1,612, orthopedics 205, pediatrics 229, communicable 317.

The hospital is accredited by the American Medical Association and the American College of Surgeons and has both a full time radiologist and pathologist.

Teaching is done mostly at the bedside in daily personal rounds with the various members of the visiting staff and at the weekly rounds of the various services at which there is full discussion of all cases presenting problems of diagnosis or treatment. In addition there are monthly staff meetings and, in ordinary times, clinico-pathological conferences.

It is the practice of the attending staff to give the interns responsibilities in the treatment of patients proportionate to the ability shown and as an intern develops more ability he is entrusted with more responsibility.

Except in extreme emergency interns are not required to do any laboratory work as this is all done by trained technicians.

There is an abundance of minor surgery as the emergency service is very active. The orthopedic service is especially active; in 1944 there were 205 house cases, in addition to as many or more outpatients.

Interns receive a monthly allowance of $100 and uniforms and operating suits are furnished.

THE HOSPITAL OF ST. RAPHAEL
New Haven

Operated by the Sisters of Charity of New Jersey.

A new General Hospital—11,000 annual admissions, 3,000 operations, 1,200 deliveries.

Rotating service in surgery and surgical specialties, medicine, obstetrics and gynecology and pediatrics.

Approved for residency in surgery and approvals pending for residencies in medicine, pediatrics, gynecology and obstetrics.

The education program includes grand rounds, journal clubs, seminars, demonstrations, x-ray and pathological conferences, instruction in surgical and post mortem pathology, clinical and clinico-pathological conferences, and oncology clinic.

Maintenance, $50 per month; one week vacation at the end of each six months service or two weeks per year.

R. R. Nesbit, M.D.
Chairman, House Staff Committee

## The Toxicology of DDT

With the increasing widespread distribution of the new insecticide DDT in the civilian market, the importance of its toxicity to man and higher animals is receiving serious consideration.

Many workers who have experimented with the material are in complete accord that DDT acts as a nerve poison when ingested or absorbed but its poisonous effect on different warmblooded animals varies widely and its acute toxicity orally is not of a high order. Dr. Fred C. Bishop, assistant chief, Bureau of Entomology and Plant Quarantine, U. S. Department of Agriculture, has stated lately that no toxicity or irritation develops from the application of 10 per cent DDT in pryprophyllite applied as a dust to the skin. This lack of toxicity when applied in that way has been amply demonstrated by the free use of the powder by hundreds of thousands of troops and civilians in louse control. DDT in solution, however, can be absorbed through the skin and this is particularly true of oil solution. There has been some opinion that DDT solutions used as spray and especially as aerosols might prove poisonous but extensive tests by the National Institute of Health showed that animals exposed to very heavy doses in strengths adequate to kill insects produced no ill effects if the animals were prevented from licking the insecticide from their bodies. From reported observations now available, it may be concluded that DDT is much less dangerous to man and higher animals from direct toxic action than many insecticides, but it should be handled with care especially to avoid ingestion and prolonged contact of oil solutions with the skin.

## 50 Per Cent Increase in Polio is Reported

An increase of almost 50 per cent in the number of infantile paralysis cases for the first five months of this year as compared to the same period last year is revealed by Dr. Don W. Gudakunst, medical director of The National Foundation for Infantile Paralysis, Inc.

A total of 740 poliomyelitis cases was reported throughout the country as of May 26 this year. At the same time last year there were only 499 cases reported.

The greatest increase was in the Middle Atlantic States where the number of poliomyelitis cases leaped from 43 to 178. In the South Atlantic States there were 106 cases so far this year as against 50 for the same time last year.

The East South Central States total was 79, more than twice the 32 cases reported last year.

Other increases were: New England States, from 15 to 30; West North Central Group, from 30 to 41; East North Central, from 41 to 75; and West South Central, from 110 to 122. Connecticut reported an increase from 3 to 5 cases.

A decrease was reported in two sections of the country. The Pacific Coast States reported only 85 cases this year as against 149 last year. The Mountain States showed a decrease from 29 to 24.

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(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## COUNCIL RESUMES MEETINGS

The Council resumed its regular monthly meetings on September 7 after the usual summer recess. There were present at the September meeting: Drs. Miller, Mullins, Howard, Murdock, Speight, Weed, LaMoure, Gibson, Campbell, Moore, Gildersleeve, Thoms and Barker. Absent: Drs. Paine and Weld.

## ADVISORY COMMITTEE TO THE U. S. VETERANS ADMINISTRATION

The Council authorized and proposed to the U. S. Veterans Administration the personnel for a Medical Advisory Committee to the Administration in the Connecticut Region. The physicians proposed by the Council have been accepted by the Administration as its Advisory Committee as follows: Joseph H. Howard, Chairman; C. Charles Burlingame, Burr H. Curtis, Cole B. Gibson, Arthur B. Landry.

### Inclusion of Professional Fees In Hospital Plan Contracts

Dr. Murdock presented the report of the special committee concerning the inclusion of professional fees in hospital service plan contracts and the referendum to members of the Society on the subject that was authorized by the House of Delegates in May 1945. Dr. Murdock's report is published in full elsewhere in this JOURNAL.

### Connecticut Medical Service

Dr. Miller presented the report of progress of the development of Connecticut Medical Service and stated that the Articles of Incorporation for the new organization are about ready to submit to the Insurance Commissioner of Connecticut for consideration as was also the Subscribers contract and Schedule of Indemnities.

### Public Relations

The Council approved the recommendations from the Society's Committee on Public Relations favoring the participation of members of the Society in civic affairs including such organizations as the Chamber of Commerce and others that are interested in the public and individual health from the lay citizens' standpoint.

### Clinical Congress Funds

It was voted that the Treasurer of the Society now make arrangements with the Chairman and Treasurer of the Clinical Congress to transfer the funds of the Clinical Congress to the custody of the Second National Bank of New Haven now serving as Agent of Treasurer of the Society and that in the future these funds be considered as a part of general and special funds of the Society and subject to the control and disbursement applied to all other funds of the Society. It was also voted that the Council make recommendations to the next meeting of the House of Delegates that in the future the Clinical Congress be considered an integral part of the State Medical Society and that the Society assume financial obligation for its continuance under such plans as may be presented by the Clinical Congress Committee.

### Restrictions On Heavy Cream Removed

The Secretary's Office has received official notice from the Department of Agriculture to the effect that Order WFO No. 13 covering the use of heavy cream has been terminated. In the letter giving this information Mr. Fitch L. Brennan, district representative of the Production and Marketing Administration, said:

"In our opinion the handling of prescriptions for heavy cream was carried on as efficiently in Connecticut as in any other State in the Union, and we are deeply grateful to you and the members of your Committee for the services rendered. We know that it took considerable time to pass on the many prescriptions submitted, and we know that an honest and sincere job was done by you."

The Secretary wishes to acknowledge the thoughtful assistance that was rendered by many members of the Society in this rather peculiar activity.

## Separated From Military Service

The following members of the Society have been returned to civilian status after military service recently:

Allen, John C., North Haven (A)
Bergendahl, Harold A., Taftville (A)
Conte, Mario G., New Haven (USPH)
Curtis, Burr H., Hartford (USPH)
Dion, Asa, Hartford (A)
Grigas, John E., Greenwich (N)
Hess, Orvan, New Haven (A)
Maynard, Harry H., New Haven (A)
McNulty, Terrence F., Hartford (USPH)
Parlato, Harry A., New Britain (A)
Post, Edward A., Waterbury (USPH)
Reiter, Benjamin R., Bridgeport (A)

## Student Members

The Council approved the application and election of the following Student Members:

| NAME | FATHER'S NAME | MEDICAL COLLEGE | TOWN |
|---|---|---|---|
| | FAIRFIELD COUNTY | | |
| Manjoney, Vincent A., Jr. | V. A. Manjoney | U. Vermont | Bridgeport |
| | HARTFORD COUNTY | | |
| Bagley, Edward R. | E. S. Bagley | Georgetown | Hartford |
| Goldenthal, Carol (m) | M. Goldenthal | *Yale | Hartford |
| Gross, Harold A. | J. W. Gross | N. Y. U. | Hartford |
| Holden, Wesley W. | A. H. Holden | N. Y. U. | Bristol |
| Swett, Norris P. | P. P. Swett | N. Y. U. | Bloomfield |
| Vazuko, Francis A. | Deceased | Yale | Newington |
| Weden, Elmer A., Jr. | E. A. Weden | N. Y. U. | Manchester |
| | LITCHFIELD COUNTY | | |
| Flint, John S. | S. H. Flint | Tufts | West Cornwall |
| | MIDDLESEX COUNTY | | |
| Harvey, David C. | C. C. Harvey | N. Y. U. | Middletown |
| Levine, Herbert | Louis Levine | N. Y. U. | Middletown |
| | NEW HAVEN COUNTY | | |
| McCluskey, Robert T. | C. A. McClusky | N. Y. U. | New Haven |
| Shea, Joseph P., Jr. | J. P. Shea | N. Y. U. | Milford |
| Yudkin, Gerald S. | A. M. Yudkin | Yale | Woodbridge |
| | NEW LONDON COUNTY | | |
| Scott, Beatrice E. | Philip Scott | N. Y. U. | Colchester |
| | WINDHAM COUNTY | | |
| Weiss, Charles P. | Abraham Weiss | Cornell | Putnam |

*Now an intern at Hartford Hospital

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(SEE PAGE 2)

## Report of the Special Committee Concerning Payment for Professional Services in Hospitals Under Hospital Service Plan Contracts

1. A special committee under the chairmanship of Dr. Thomas P. Murdock recommended to the House of Delegates at its annual meeting in May 1944 that the Society disapprove of the payment of any professional fees under hospital service plan contracts. Action upon this report was tabled at the annual meeting of the House of Delegates in May 1944.

2. Later the Council recommended that this report be taken from the table at the special meeting of the House of Delegates in December 1944 and recommended the adoption of the report.

3. The report was taken from the table at the meeting of the House of Delegates in December 1944 and unanimously approved by the House of Delegates, thus placing the Society on record as disapproving the inclusion of professional fees in hospital plan contracts to a referendum of all the members of the Society.

4. At the annual meeting of the House of Delegates in May 1945, it was voted that the Council name a special committee for the purpose of referring the subject of the inclusion of professional fees in hospital plan contracts to a referendum of all the members of the Society.

5. The special committee consisting of Thomas P. Murdock, Joseph H. Howard, George H. Gildersleeve, Ralph T. Ogden, Berkley M. Parmelee and Hugh M. Wilson was appointed to act upon the resolution concerning the referendum passed by the House of Delegates.

6. Preceding the appointment of this committee, the Council of the Society had endeavored to arrange a conference with the Board of Trustees of the Connecticut Hospital Association for the consideration of the payment for professional services rendered by physicians engaged in one way or another by the hospitals. The arrangement of this conference was delayed for many months by the Board of Trustees of the Hospital Association but was finally held in April 1945 and was attended by many members of the Council and others who later became members of this committee. The outcome of this conference was a lengthy memorandum from the Board of Trustees of the Hospital Association which had been approved at its annual meeting of May 1, 1945. This memorandum restated the fixed policies of the hospital administrators and offered no aid in solving the problem under consideration.

7. During its deliberations, this committee met with the Council on a number of occasions and the committee and the Council gave further consideration to the statement of principles that was submitted by the Section on Radiology under date of December 8, 1944. As a result of this further consideration on the part of the Council, these Principles were approved on behalf of the Society. The Council directed the Secretary of the Society to restate and emphasize to Connecticut Hospital Service, Inc., the Society's disapproval of the inclusion of professional fees in hospital service plan contracts.

8. The Secretary of the Society was directed to send copies of the approved principles to the chairmen of the Board of Directors of each of the voluntary hospitals in Connecticut, asking that they be given consideration as guiding principles regulating the practice of radiology in hospitals in Connecticut.

9. The directions contained in paragraphs 7 and 8 have been carried out. As a result of the statement of disapproval of the inclusion of professional fees in hospital plan contracts sent to Connecticut Hospital Service, Inc., the Society received a communication from Mr. Harry B. Kennedy, president of Connecticut Hospital Service, and a reply to that letter was formulated and approved by the committee and sent to Mr. Kennedy over the signature of the Chairman of the Council, Dr. Miller, on behalf of the Society. This letter set forth the Society's objections to the inclusion of professional fees in hospital plan contracts and urged the Hospital Plan to attach a supplementary statement to its existing contracts stating that payment for professional fees would be made under the contract when the hospital billed for those fees in the name of the physician rendering the service. This exchange of correspondence was published in its entirety in the September issue of the Connecticut State Medical Journal.

10. In the light of these events the committee is of the opinion that:

(a) Progress has been made toward a revision of the hastily arrived at policy of including payment for professional fees under hospital plan contracts.

(b) The Society shall continue its efforts with the Board of Directors of hospitals to revise existing policies relating to the payment of radiologists, anesthetists, and other medical personnel.

(c) Radiologists and others engaged by hospitals, either on a contractual or full time salary basis, should make local efforts with their hospitals toward the adoption of the principle that bills for their services should be rendered in their name.

(d) No good purpose would be served at this time by a referendum to the members of the Society on the subject of the inclusion of professional fees in hospital plan contracts and it recommends that action under that part of the resolution passed by the House of Delegates in May 1945 which prescribed such a referendum be postponed indefinitely.

## State Medical Society Presidents Meet in Denver

The original group of seventeen presidents of State Medical societies which met in Detroit in April has been enlarged to twenty-six by the inclusion of the western states. Ten presidents and other officials of western state medical societies met in Denver, June 28 and 29, at the invitation of the Colorado and California Medical Associations for a public relations conference. The need for the creation by the state societies of a Drafting Committee for National Legislation was presented and discussed and resulted in the appointment of a special committee to study the project. Commercial radio broadcasting by medical societies as carried out in Michigan was discussed and also referred to a special committee.

After listening to a presentation of "Voluntary Medical Care Programs" by L. F. Foster, secretary of the Michigan State Medical Society, the following recommendations were presented to the conference and unanimously adopted:

1. That each state here represented, by any method it chooses, prepare and formulate a statement of its position on medical care programs.

2. That each of the 26 states (represented at the Denver and Detroit Conferences) file the name of its president with the Michigan State Medical Society; that the Michigan State Medical Society send a complete list of the state presidents to all the 26 states; that each state send its statement of position on medical care programs to all other state presidents prior to a conference of presidents of all the 26 state societies.

3. That this Committee approve all methods of medical public relations, including radio.

Representatives from California informed the conference that their State Medical Association dues for 1946 had been raised from $20 to $100 in order to combat attempts to socialize medicine. Two compulsory health insurance bills were introduced into the 1945 session of the California legislature, sponsored by Governor Warren and by the C.I.O. Both were defeated.

## Drs. Gold and Nichols Win Golf Awards

In the recent tournament of the Connecticut State Seniors's Golf Association held at the Shuttle Meadow Country Club, New Britain, two of our members won fame. To James Douglas Gold of Bridgeport was awarded the Wilcox Shield. Dr. Gold was also elected vice-president of the association. Ralph W. Nichols of New Haven tied for the club championship with scores of 78 and 81.

## Dr. F. G. Blake Receives Typhus Commission Medal

Dr. Francis G. Blake, Dean of the Yale School of Medicine and Sterling Professor of Medicine, was awarded the United States of America Typhus Commission Medal at a special ceremony September 13 in Washington, D. C. The presentation was made by Major Gen. Norman T. Kirk, Surgeon General, U. S. Army.

The award was "for exceptionally meritorious service performed in the investigation of scrub typhus fever in New Guinea and as Director of the special Commission of the Army Epidemiological Board and U. S. A. Tyhus Commission which was sent to the Southwest Pacific Area in 1943."

Dr. Blake since 1943 has been consultant to the Committee on Medical Research of the Office of Scientific Research and Development as well as President of the Board for the Investigation and Control of Epidemic Diseases in the U. S. Army since 1941.

## Tuberculosis Control in Connecticut

The Connecticut Tuberculosis Association has issued its fifth annual report for the year ending March 31, 1945. In this report attention is called to the fact that sanatorium beds and case-finding facilities in Connecticut are more adequate than in most other states, and with the second mobile x-ray unit now in operation by the State Tuberculosis Commission, an extensive service is being rendered not only to industrial workers but to other adult groups.

The Connecticut Tuberculosis Association has established a special fund of $5,000, contributed voluntarily by the local associations, to assist in the continuation of industrial x-rays as an emergency measure during the post war period.

Last year's Christmas seal sale broke all records with a total of $273,639. In addition to this project, the Association conducted during April an early diagnosis campaign and in October, together with the State Department of Education and the State Department of Health, a conference on school health education.

Joseph I. Linde, health officer of New Haven, represented the State Medical Society on the Association's Board of Directors during the past year.

## Mt. Sinai, Hartford, to Have $750,000 Building

Mt. Sinai Hospital directors have announced plans for a $750,000 building fund campaign for the construction and equipment of a new and enlarged hospital building. The drive will be officially launched November 1, although some solicitation of special gifts will start before that time.

The hospital acquired some years ago the site of the former Children's Home at Blue Hills and Tower Avenues and has been waiting for the end of the war in order to build larger quarters at that location than those it now occupies on Capitol Avenue.

A start on the building fund has already been made. In 1940, the hospital conducted a building drive and was successful in raising a substantial sum of money. However, before construction could begin, war was declared and plans had to be abandoned temporarily. Since 1940, both the demands upon the hospital and the costs of building have so sharply increased, the directors estimate, that it is now necessary to ask for a larger sum in order to construct a building specially designed for use as a hospital.

The present three-story structure on Blue Hills Avenue will be converted to nurses' quarters and administrative offices. Plans for the new hospital building, which will provide 106 beds, include the latest modern equipment for pathology, physiotherapy, cardiography, radiography, fluoroscopy, cystoscopy and other scientific methods.

The new Mt. Sinai Hospital will have a maternity unit, for which there has not been room in the present building, and also adequate out-patient facilities. Modern kitchens are planned to provide for all dietary needs of patients.

Demands upon the hospital have increased considerably in recent years. Mt. Sinai was established in 1923 and treated 830 patients that year. In 1944, the hospital treated 1,673 patients.

## Hartford Hospital Dedicates Memorials

Approximately 350 persons attended ceremonies at Heublein Hall June 21 at which units of the South Building of Hartford Hospital which had been made possible through memorial subscriptions were formally dedicated. William H. Putnam, vice-president of the hospital, presided.

On display beneath the speakers' rostrum were dedicatory tablets for the 27 memorials in South Building, first of the major structural units of the new Hartford Hospital to be completed. Sections of this building that were memorialized include the second floor housing maternity wards, and the fifth floor used for obstetrics and including a delivery suite and premature nurseries, a medical clinic, a social service room, an isolation nursery, nurses' conference rooms, waiting and treatment rooms, nurseries and rooms for patients.

Plans for the completion of the hospital expansion program have reached a stage where the work may go forward whenever conditions permit, George J. Mead, chairman of the hospital's executive committee, said. South Building, he said, has served as a working model of various facilities contemplated in the new and larger building yet to be constructed. This operating experience has made improvements of detail in the design of the new structure possible.

Completion of the building program, Mr. Mead estimated, will require two and a half to three years.

From the remarks of John O. Enders, hospital president, and Dr. Wilmar M. Allen, director, it was learned that in the 34 months since the opening of South Building, 13,752 babies have been born there. This is "a population sufficient to replace the whole town of Enfield," said Dr. Allen.

Ambulatory patients already have made 22,500 visits to clinics housed in the new building, Dr. Allen reported. Declaring that "the best defense is a good offense," he envisaged the general hospital of the future as a place where doctors, nurses, other professional groups, skilled technicians and forty-two other groups of workers will carry on "a defense in depth against the hazards of life and the

generally invisible mental and physical enemies of mankind."

Speaking of his work as chairman of the memorial gifts committee in the recent building fund movement, Barclay Robinson said: "Nothing that is human is finer than what I was privileged to see and know. Hartford is a good place in which to be born. I have always thought so, and I am more than ever convinced of this now."

Subscribers contributed $744,500 for memorial units in South Building alone, Mr. Robinson said, showing devotion to the community, an understanding of the need and a great generosity.

## Drug Plant Culture Increasing in Central America

According to *Inter-American Economic News*, Central American republics are in position to look to greater participation in hemisphere drug trade as a result of intensified cultivation of medicinal plants for United Nations needs.

Ipecacuanha roots, source of ipecac, have become one of the leading export items of Nicaragua and Costa Rica. El Salvador is the chief source of balsam. Costa Rica and Honduras are supplying sarsaparilla. Guatemala and Costa Rica are developing a cinchona plantation industry. Guatemala also is planning cultivation of digitalis and belladonna.

One stimulus to this development is the big medicinal requirements of the fighting forces. Quinine, formerly obtained from the Far East, is a prime necessity on tropical battlefronts to combat malaria. Balsam is another indispensable battlefront drug for treatment of wounds. Ipecac, a purgative, is the source of emetine, an alkaloid for treatment of amoebic forms of dysentery.

Prospects for Central American drug production in postwar trade are foreseen by John F. Hennessey, Jr., of the Division of Economic Information of the Pan American Union, Washington, in a report on Central American production of strategic materials.

He lists these wartime developments in Central America's drug trade:

Six quinine plantations are in cultivation in Guatemala. One of these—"El Porvenir"—contains approximately 1,000 acres of cinchona trees and is the largest in the Western Hemisphere.

Cinchona tree nurseries are in operation in Costa Rica under a program in which the Costa Rican government has agreed to make available 10,000 acres for cinchona cultivation.

Development of plantation sources of quinine in both countries is carried on with assistance from United States specialists.

El Salvador substantially increased production of balsam. Approximately 50,000 trees are capable of an annual yield of from 300,000 to 500,000 pounds of crude balsam. Nicaragua also is increasing balsam production.

Mr. Hennessey noted that Central America possesses many other medicinal plants in sufficient quantities to justify investigation of their utilization. Among them he included the irritant, sabadilla, and copalche and cedron, both of which have medicinal properties.

He said a large variety of drug plants are native to Honduras, including liquid amber, copaiba and high quality sarsaparilla.

"The most important requisite for drug cultivation is hand labor, which Central America is capable of supplying," he pointed out. "Intensive cultivation produces good results, so returns by the acre of these drug plants would be profitable in Central America, where farms are generally small, new cash crops are needed and labor is plentiful.

"Central American drug production is much more than an emergency enterprise. It is a step toward the integration of agriculture in this region so that the export crops of other parts of the Western Hemisphere will be largely complementary, rather than competitive. This will strengthen the economies of individual republics and at the same time make for economic unity among all the Americas."

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(SEE PAGE 2)

# MEDICINE AND THE WAR

## Lieut. Col. Townsend Receives Bronze Star Medal

Lieutenant Colonel Wilmot C. Townsend, AUS, of Hartford has been awarded the Bronze Star Medal for meritorious service while directing the medical activities of the 81st Station Hospital. The hospital also received a meritorious service plaque for excellent work in returning 83 per cent of its patients to active duty.

Entering the service on Septmeber 10, 1942, with the rank of major, Dr. Townsend was stationed in North Africa and later in Italy. He is expected to return home in the near future.

The citation reads as follows:

"In connection with military operations in the Mediterranean Theater of Operations from July 12, 1943, to May 8, 1945, as chief of the medical service 81st Station Hospital during this period, Lieutenant Colonel Townsend was responsible for the care of 7,643 patients, 83 per cent of whom were returned to duty. Because of his outstanding professional ability, his attention to duty and his personal attributes, he was a source of inspiration to his patients and his co-workers. In addition, Lieutenant Colonel Townsend was a gifted teacher, and the personal interest he displayed in the development of his junior staff members was in a great degree responsible for the superior standards of medical service throughout his unit, thereby reflecting great credit upon himself and the medical corps of the Army of the United States."

## Major Burdette J. Buck Awarded Medal

For meritorious service, the Bronze Star Medal has been awarded to Major Burdette J. Buck, former Hartford physician and now commanding officer of the 37th Field Hospital in the Philippines. Major Buck was cited for meritorious achievement in support of combat operations against the enemy on the island of Negros in the Philippines where he served as chief of medical service in the 37th Hospital. He assumed command of the organization June 1, 1945. In addition to the Bronze Star, Major Buck has earned four campaign stars for participation in the New Guinea, Luzon and southern Philippine campaigns.

Major Buck was graduated from Harvard Medical School and interned at the Hartford Hospital. He practiced in this city from September, 1928 until he entered the service in August 1942, with the commission of major. Prior to going overseas in February, 1944, he was stationed at Fort Custer, Mich., and Camp Atterbury, Ind.

## Major Heidger Awarded Bronze Star Medal

The War Department has announced recently the award of the Bronze Star Medal to Major Luther C. Heidger, posthumous, of Stratford.

## Captain Valenski Receives Citation

Word has just been received that Captain T. J. Valenski, AUS, of Thompsonville has received an American citation for his service through the Italian, French and German campaigns. Captain Valenski is the recipient of two battle stars and was on duty on the U. S. Meritorious and later on the U. S. Army Hospital Ship Blanche F. Segnien before returning to the United States.

## 165th Station Hospital Commended

In a communication from the Headquarters of the Eighth Army dated August 2, 1945 the 165th Station Hospital, G. I. Sneidman, Colonel, MC, Commanding, is commended "for its superior performance and outstanding devotion to duty during operations against the enemy from 26 December 1944 to 30 June 1945. The untiring effort and high degree of professional skill evidenced by all officers and enlisted men have contributed materially to the alleviation of suffering of the wounded, and the survival of many who were critically wounded.

The inspiring manner in which the 165 Station Hospital has carried out its mission reflects great credit upon the Medical Department and the military service as a whole."

## Surgeon General Announces New Officer Release Policy

A revised point system program which will return 13,000 physicians, 25,000 nurses, 3,500 dentists and an undetermined number of other Medical Department officers to civilian life by 1 January 1946 was announced 14 September 1945 by Major General Norman T. Kirk, The Surgeon General.

Under the plan these Medical and Dental Corps officers who have 80 points, are 48 years of age or have been in the Army since before Pearl Harbor will be released as surplus officers unless they are specialists in eye, ear, nose and throat work; plastic surgery, orthopedic surgery, neuropsychiatry and are laboratory technicians. These specialists will be released if they were called to active duty prior to 1 January 1941.

This is a drastic lowering of points below the previous plan which was based on an adjusted service score of 100 for non-scarce Medical Corps officers and 120 for those in scarce categories.

A similar drastic reduction was made in the point score for nurses, who are now eligible for discharge if their rating is 35 or more, or if they are 35 years old. In addition all married nurses and those with children under 14 years are eligible for immediate separation. Physical therapists and dietitians are eligible under the same conditions if their point score is 40 or more, or if they are 40 years old.

Veterinary Corps officers will be eligible for discharge if they have a point score of 80 or more, if they are 42 years old, or if they joined the Army prior to 1 January 1941.

Medical Administrative and Sanitary Corps officers with point scores of 70 or more, who are 42 years of age or have been in service since before Pearl Harbor will be released as surplus.

General Kirk added that in some cases essential officers may be retained by military necessity until replacements are shifted to their positions but none will be held in service after 15 December 1945 without their consent.

Every effort will be made to release these officers at the earliest possible moment consistent with military needs, General Kirk added.

It is also anticipated that, on the basis of an army of 2,500,000 men, a total of 30,000 doctors, 40,000 nurses and 10,000 dentists will be released by July 1946 and if the armies of occupation and troops in the United States are concentrated at large posts these figures will be exceeded. These figures represent approximately 70 per cent of the peak strengths at VE-Day of these corps.

## War Medicine: Vol. 8, No. 1, July 1945

This issue of *War Medicine* contains several articles pertaining to aviation medicine. Lieutenant Colonel John E. Leach, MC—AUS, contributes two papers on "Diseases and Defeats in Aircrew Trainees," one on the cardiovascular system, the other on the pulmonary system. His comments are interesting. "Electroencephalogram in Syncopal Reactions" by Captain Oscar Sugar, MC—AUS, is the report of a study with the aid of encephalography of cadets suffering neurocirculatory collapse with unconsciousness at a simulated altitude of 18,000 feet in the low pressure chamber. The author's chief conclusion is that such reactions are probably of psychoneurotic rather than epileptic origin. Major E. S. C. Ford, MC—AUS, contributes a report entitled "Principles and Problems of Maintenance of Fighter-Bomber Pilots." His conclusions are particularly valuable because they are directed to the improvement of America's flying personnel in the post war world.

Three neuropsychiatric articles appear in this issue. "Camptocormia" by Lieutenant Colonel S. A. Sandler, MC—AUS, portrays an interesting experience with nineteen cases of this hysterical phenomenon. Captains Louis Linn and Martin H. Stein, MC—AUS, contribute a short "Psychiatric Study of Blast Injuries of the Ear," and Major Max Levin, MC—AUS, discusses "Hysteria as a Device to Prolong Hospitalization and Evade Military Duty." This latter subject is an old one about which volumes were written during and after World War I.

Miscellaneous articles include: "Optical Service Units of the Navy" by Lieutenant Commander Jack P. Cowan, MC—USNR, a short interesting account of these units in supplying, replacing and repairing spectacles for officers and men in the field; a preliminary report on "Military Value of Standard Test of Heart Function with Electrocardiograms in a Staging Area" by Lieutenant Colonel A. A. Goldenbloom and Captain A. A. Dumanis, MC—AUS, in which the use of the exercise test with electrocardiograms is urged in the examination of doubtful personnel under consideration for arduous assignments; a report of the use of penicillin sodium in the treatment of 439 patients with sulfonamide resistant gonorrhea in a station hospital by Major J. John Kristal, MC—AUS.

Twenty-four pages of abstracts from recent American, British, Australian and Canadian journal publications, and five book reviews complete the issue.

## General Simmons Aids in German Public Health Program

Plans for public health control in the American Zone of Germany, which will be coordinated with Russian, British and French groups to insure unified policies, were described recently by Brigadier General James S. Simmons, Chief of Preventive Medicine of The Surgeon General's Office.

General Simmons, who went to Germany with Colonel Thomas B. Turner, director of Civil Public Health Division of the Army Medical Department, assisted in setting up a new division of public health to function as part of the Allied Control Council as the responsible agency for the control of public health in the American Zone. Major General Morrison Stayer, formerly Chief Surgeon in the Mediterranean area, will be in charge of this new division which will continue during occupation of Germany.

The Army's Civil Public Health work in Europe was originally organized under Major General Warren F. Draper, formerly assistant surgeon general of the United States Public Health Service, who was loaned to The Surgeon General of the U. S. Army. During the SHAEF period he served as chief health officer for the civilian public health program of the Army until the recent dissolution of SHAEF.

The new Division of Public Health of the U. S. Group Control Council is responsible for an orderly and effective health program in the U. S. Zone of Germany so that no focal point will develop to form a potential for epidemic diseases. In spite of the widespread disorganization and dispersing of populations during the stress of war, epidemics have been kept to a minimum, General Simmons said, due to tremendous advances in military medicine and techniques, and also because of the closely coordinated efforts of agencies concerned with the health of our troops abroad.

He offered as an example of effective epidemic control in Europe, the program set up to prevent the spread of louse-borne typhus which increased rapidly in Germany as prisoners began to leave concentration camps and prisons.

In order to prevent the spread of the disease westward, a sanitary cordon was established by SHAEF along the Rhine last March and orders were issued that all civilians would be deloused before crossing it. In addition, delousing was made routine for all typhus patients, for all immediate or remote contacts, and for displaced persons and others who had been in Germany, Poland, or the Balkans and for refugees and inmates of concentration camps, jails, or other institutions.

As planned by The Surgeon General and the U. S. A. Typhus Commission, a stockpile of more than one million pounds of DDT had been placed in readiness with plans for delousing of some eighteen million persons in Europe as soon as military operations permitted, General Simmons said. With the stockpiling of DDT, the delousing program was put into effect as quickly as possible and this has saved the European continent from the typhus scourge that raged through Europe following the first World War.

Health missions were dispatched from SHAEF to work with governments to restore public health facilities and to see that medical supplies have been made available. These health missions, he said, have been tremendously influential in helping to set up public health programs and have also served to stabilize health control work over the continent.

Production of vaccines is now being stepped up in various European countries in order that they may meet their own needs as far as possible in the preventive measures that will be necessary in the coming months. Nutrition teams have been sent out to survey the food situation. He said that distribution of food is the principal problem in providing for the nutritional needs of people in the war-torn countries.

## Army Establishes Seven Centers for Tropical Skin Disease

Establishment of seven centers specializing in the treatment of tropical skin disease has been announced by Major General Norman T. Kirk, Surgeon General of the Army.

The centers, it was explained by Major Clarence S. Livingood, of Philadelphia, consultant in dermatology to General Kirk, will be devoted to the care of men returned from overseas, particularly the Pacific areas. The number of beds involved was not made public, as the program envisions an elastic setup capable of being expanded or contracted as the need arises.

The centers will be at Wakeman General Hospital, Camp Atterbury, Indiana; Brooke General

Hospital, Fort Sam Houston, Texas; Moore General Hospital, Swannanoa, North Carolina; Harmon General Hospital, Longview, Texas; and in the U. S. Army General Hospitals at Camp Edwards, near Boston, Massachusetts; Camp Butner, near Durham, North Carolina; and Camp Carson, near Colorado Springs, Colorado.

"The new arrangement will make possible better distribution of the limited supply of specialists in dermatology," Major Livingood said, "and thus give these soldiers the best possible treatment."

At the same time, Major Livingood said that there is no basis for fear of tropical skin infections spreading in this country, because practically none of these diseases are contagious and no patient with a transmissable skin disease would be allowed out of an Army hospital until he was non infectious.

Acne was given as an example of a common skin disease which flares up in the tropics. One Army doctor working on the problem used the word "explosive" in describing the cases he had seen in the Pacific.

"The skin diseases are not fully appreciated by the public in the glare of the more dramatic developments of surgery and problems like malaria," Major Livingood said. "But it is true that in tropical areas about eight per cent of all Army hospital admissions—or one in every 12 or 13—is due to skin conditions."

One of the dermatologist's main efforts, Major Livingood said, is to keep men from "overtreating" skin disease; but the good nutritional state of the American soldier helps protect him from some of the skin diseases common to natives of tropical areas. Major Livingood cited tropical ulcer as an example, saying ulcerations were frequent enough among Americans, but the peculiar tropical ulcer is rare and he thinks that the native gets it because of his poor diet while the American is free of it because he is well fed.

## Plastic Artificial Eyes

Thirty installations, twenty-nine general hospitals and one regional hospital have been designated plastic eye centers for the Army Medical Department. "There is no existing backlog for plastic eyes and it is not contemplated that any more centers will be opened," said Major Trygve Gunderson, MC, Chief Consultant in Opthalmology to Major General Norman T. Kirk, The Surgeon General.

All existing laboratories have adequate space, personnel, and supplies, with the exception of one general hospital, and action is being taken to expand the facilities so that production can be increased at this establishment.

As of June 30, 1945, approximately 5,100 plastic artificial eyes have been made and fitted. In addition, the plastic eye laboratories have made conformers, eye spheres and other appliances for the eye clinics.

Experimental work is still being carried on in the plastic artificial eye program. Technicians are continually endeavoring to improve and give these plastic eyes greater mobility and lessen abrasion.

Three teams of officers and enlisted men who are experienced in making plastic artificial eyes are overseas, and four additional teams are now being trained in this work.

## Streptomycin Being Studied

A new drug, streptomycin, companion to penicillin as a killer of bacteria is being studied and undergoing tests by the Army Medical Department to determine its suitability as a germ killer in saving the lives of wounded and sick American soldiers.

The new drug shows possibilities which may prove to be as important to the medical profession as was the discovery of penicillin. Streptomycin is a killer of gram-negative bacteria, such as gonococcus, cholera, dysentery, typhoid, tularemia and salmonella food poisoning. Penicillin is a killer of gram-positive bacteria, such as pneumococcus, streptococcus, staphylococcus, tuberculosis.

Even though the new drug is still in the laboratory stage, some is being produced and small quantities are being made available to the Medical Department for experimental purposes, according to Brigadier General Hugh J. Morgan, Chief Consultant in Medicine to Major General Norman T. Kirk, The Surgeon General.

Since streptomycin and penicillin resemble each other in many respects, General Morgan pointed out that experience gained in the production of penicillin will aid materially in the production of the new drug. The production process, however, is slow and tedious and it will be some time before the drug is available in any quantity, he said, just as it took more than two years to bring penicillin into production for general use.

Dr. Selman A. Waksman of the Department of Microbiology of the New Jersey Agriculture Experimental Station at Rutgers University, New Brunswick, New Jersey, is given credit for the dis-

covery of streptomycin. Ever since the discovery of penicillin, Medical Department and civilian bacteriologists as well as Army and commercial laboratories have been searching for a drug that would fight the diseases that penicillin cannot cure. Dr. Waksman reported that he had discovered streptomycin and had reported on it some twenty-nine years ago during experiments with soil bacteria.

## 30,000 More Physicians Needed in Post War Years, A. M. A. Says

Even after Uncle Sam has completed his job of demobilization, the United States will need about 30,000 more physicians than before the war, according to the September 1 issue of *The Journal of the American Medical Association.*

In the 45th annual report on medical education in the United States and Canada, Victor Johnson, PH.D., M.D., secretary of the Council on Medical Education and Hospitals of the American Medical Association, said that during the past year there have been virtually no able bodied male students in medical training.

"Even after demobilization is complete, we shall probably need about 30,000 more physicians than before the war, primarily because of the requirements of the Veterans Administration (about 15,000 physicians) but also because of the needs of the peacetime Navy (about 5,000) and the Army plus possibly a compulsory universal military training program (about 10,000)," the Council's report said, adding:

"This estimate disregards extra physicians required to provide replacements for casualties among medical officers, medical assistance to liberated countries and the more complete and extensive medical care demanded in this country.

"Even if admissions, enrollments and graduations from our medical schools should continue at the present levels, only about half of this need would be met since 40,000 students enrolling would receive the M.D. degree in the period 1942 to 1948 and 24,000 physicians will have died during that time. Thus under the most favorable conditions only about 16,000 additional physicians will be available after the war to do the work of 30,000.

"From now until at least 1947, medical school freshmen must be women, or men who were physically disqualified, under or over the draft ages or veterans. Because people in these categories are limited in numbers, those admitted to our medical schools in the next year or two will be appreciably reduced in numbers or in quality."

Touching on the accelerated medical training program during the war period, the report said:

"By June 30, 1945 all medical schools in the United States except 10 and all but four in Canada had completed a cycle of four graduating classes in three calendar years. During these three years, to June 30, 1945 there have been 20,662 graduates in the United States. By comparison there were 15,535 graduates in the three immediately preceding war years to June 30, 1942. This represents the graduation of an extra 5,127 students in the past three years. This contribution of medical schools to the successful prosecution of the war is immeasurable. . . ."

The Council added, however, that "during the past three years there has been a fairly general agreement that the accelerated program . . . has been educationally undesirable."

The report said that Army students now in A. S. T. premedical work will be available for one class in 1945 in each medical school, and Navy V-12 men will also be assigned to 1945 entering classes. However, the medical schools estimate a reduction in the 1945-46 entering freshmen classes.

The Council strongly condemned recent proposals to establish new medical schools to meet the wartime shortage of physicians.

"There is no justification for the establishment of a medical school to meet such an acute temporary emergency as the absence of physicians on military duty," the Council said. "Any overall increased present or post war need for additional physicians occasioned by the war can be provided by existing approved schools. The maldistribution of physicians as between the states or between urban centers and rural areas is a problem to be attacked primarily by other means than the production of more doctors in a given state."

The Council reported that in the 77 U. S. medical and basic science schools during 1944-45, there were 24,028 students studying medicine, which is an insignificant decrease of 638, or 2.6 per cent from the enrollment in the preceding session. Women students in the United States numbered 1,352 as compared with 22,676 men. In Canada there were 228 women and 2,325 men.

"During the 1944-45 session," the Council reported, "there were 129 part time or special students

and 140 graduate students enrolled in some of the medical courses in 40 medical and basic science schools in this country and Canada. These numbers represent still further decreases below the figures of a year ago. In 1940-41 there were 1,167 graduate students in our medical schools. Last year's 140 is only 12 per cent of this number. The Selective Service System and the Army and the Navy have insured a deficiency in medical students, in quantity or quality, in the next few months or years. They have also provided for an even more prolonged deficiency in medical school teachers and investigators in the basic sciences."

## General Kirk Reports On Malaria Effects

Fear due to lack of information can cause more harm than malaria itself. Major General Norman T. Kirk, Surgeon General of the Army, declared in his first public report on the effects of this disease on the individual.

With the prospect of thousands of soldiers returning to this country from malarious regions, General Kirk made an appeal for a better understanding of the problem so the public will realize that, with a few simple precautions, malaria is not a disease that should give undue concern either to infected service men or to their families.

"The soldier who, through ignorance, worries about malaria and the chances of relapses," he said, "will suffer more ill consequences than the man who understands that with proper care this disease is not of serious import from the standpoint of the patient's general health. This very knowledge will contribute considerably to the individual's well being and fitness."

General Kirk pointed out that families should not consider soldiers infected with malaria a menace to them or the community, provided the malaria sufferer is taking treatment or promptly obtains medical care when symptoms occur.

There are a number of types of malaria, but the two that concern American troops are benign tertian malaria, which is rarely a serious disease, and malignant tertian malaria, which without treatment may be fatal. The latter type is cured by atabrine so that it is not a problem when properly treated. The attacks of malaria which soldiers will suffer after return to this country will be due to benign tertian malaria. This is the one type which is of military significance to American troops.

The service man infected with benign tertian malaria can continue with his usual arduous combat duties as long as he takes the necessary small doses of atabrine. Benign malaria is rarely cured by atabrine. However, this drug suppresses the disease. When a man with benign malaria stops taking atabrine, the usual symptoms—chills, fever, headache, and nausea—may appear.

In the majority of cases the disease has run its course after a man has suffered a few relapses, and no permanent damage has been done. Out of 1,000 cases, about one-third will have only one attack. There will be about 40 out of 1,000 who will suffer ten relapses, and only about one in 1,000 will have as many as 20 attacks. Relapses become less acute as time goes on.

When attacks do occur, the symptoms are rapidly relieved and all progress of the disease is quickly suppressed if the proper medical care is given the patient. In most cases this can be accomplished within 48 hours, according to General Kirk.

"As a result of prompt and efficient action," he said, "attacks of malaria by themselves cause only brief incapacitation and result in no permanent damaeg to the body."

General Kirk stressed the point that malaria can be spread only by the anopheles mosquito. Even if a man is infected, the anopheles mosquito cannot transmit the disease unless it has bitten the victim during a relapse and before medical treatment has been secured. In most parts of the United States there is little likelihod of this since mosquito control measures are adequate.

Infected individuals who are not taking regular suppressive medication are particularly subject to relapses if they engage in strenuous work, or if they suffer from exposure, or if they indulge in drinking to excess.

One phase of malaria treatment that causes concern to many victims is the yellow color the skin takes on as a result of using atabrine. This color is not due to jaundice or any other malfunctioning of the body. It is caused directly by the yellow color of atabrine which is deposited in the skin. The yellowness will disappear a few weeks after the use of the drug is discontinued.

Deaths due to malaria since the beginning of the war have been rare. They are nearly always associated with other diseases and with circumstances which cause delayed or inadequate treatment, Army

records show. In the early stages of the Pacific war, malaria did more damage to American soldiers than Jap bullets—in disabling troops, but not in killing them.

## Major General Grant Commends India-China-Burma Medical Service

AIR SURGEON CALLS COMMAND SUPPORT BEST EVER SEEN IN ARMY

*Hq. Calcutta*—The ICB medical service has been commended by Major General David N. W. Grant, the air surgeon, Army Air Forces.

In a memorandum to Brig. Gen. William H. Tunner, General Grant wrote: "Without exception, the command support given to the medical department is superior to any I have seen in my 30 years' service in the Army."

The statement also said the air surgeon found "on the whole, the sick reports were even lower than those in the continental United States."

CREDIT TO MEN

Commending the many persons who shared in the achievements, General Grant specifically called attention to the work of Colonel Edward A. Abbey of New Haven, Connecticut, division flight surgeon; Major Duncan V. Luth, 1333 BU flight surgeon, and Captain Austin E. Lamberts, 1352 BU (Search and Rescue squadron) flight surgeon.

These three men accompanied the air surgeon on his extensive tour of ATC stations in India and Burma.

Colonel Abbey gave the credit to the men in his organization, stating that the splendid record was only possible because of their hard work and conscientious efforts in the medical program. Pursuant to ATC's policy of sending the best men to the toughest places, the medical personnel were hand-picked for assignments. Many had previous positions with the Caribbean wing where they gained valuable knowledge in the prevention and cure of tropical diseases.

ADVISORY CAPACITY

The division flight surgeon credited this for the low sick rate at ICB bases. Medical personnel are experienced in the prevention of diseases, adept in destroying sources of infection.

Incidence of malaria, one of the most potent and prevalent tropical diseases, is relatively low in this area because malaria control is so strictly enforced.

Colonel Abbey pointed out that today mosquitoes are "virtually absent" from many of the bases, whereas a year ago they were present in swarms. Other factors are the sanitary conditions under which food is prepared and served and also the strict hygienics with which native workers must comply before they can work on Army bases.

LAUDS TEAMWORK

Colonel Abbey said the commanding general and the commanding officers of division bases have given wholehearted cooperation. The difficult task of keeping the men healthy has been made easier through the team-work, he stated.

Colonel Abbey feels these men deserve the highest credit for their work. They are not only responsible for the welfare of the men on the ground, but they are constantly seeking new ways to aid the men during their flights over the Hump.

More than anyone else, however, it is a tribute to personnel—the ICB soldier. In lands that are filled with disease—where precautions regarding food, water and protection from insects are paramount—ICB soldiers have taken good care of themselves as the division health records prove.

Without their wholehearted cooperation, General Grant's splendid commendation would not have been possible.

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Reprinted from "Hump Express," Air Transport Command newspaper, India-China-Burma theater.

## Blinded Vets Launch New Organization

A new organization, the Blinded Veterans Organization, was recently formed at a meeting of trainees and visiting veterans at Old Farms Convalescent Hospital (Special) at Avon, Conn. Its purpose is the "promotion of the best interests of its members" and "the promotion and support of the democratic way of life."

Lt. Raymond Frey, of Lebanon, Pa., former officer who was blinded in the service and who now is employed as blind consultant at Valley Forge General Hospital, is a member of the board. Lt. Frey was the first blinded patient to be admitted to this hospital. He has worked here as a civilian in blind education and rehabilitation for the past fourteen months.

Interested veterans should write to the Blinded Veterans Association, c/o Old Farms Convalescent Hospital, (Special) Avon, Conn., for further information.

## NEW LIBRARIAN FOR THE ARMY MEDICAL LIBRARY

Willis E. Wright assumed his new duties as Librarian of the Army Medical Library on 1 July 1945. He will be assisted by Miss M. Ruth MacDonald, formerly head cataloger of the Detroit Public Library, who is head of the newly organized Catalog Division and her assistant Miss Irene Jones. Scott Adams has been named as Chief of the Acquisition Division.

Authorization has been received for thirty-one additional staff members for the Library. This brings the total authorized personnel strength to 156 including six military and one hundred fifty civilian employees. Eighteen members of this total are at present assigned to the Cleveland Branch of the Library.

## COURSE IN DISEASES OF PACIFIC AREA GIVEN AT CARLISLE BARRACKS

Selected medical officers being redeployed to the Pacific areas are attending a two-week course in diseases of the Pacific area given at the Medical Field Service School, Carlisle Barracks, Pennsylvania. The purpose of the course is to acquaint them with special problems in the prevention and treatment of diseases peculiar to the Pacific area. Officers with service in the Pacific are used as instructors in the course and bring to the student officers the benefit of their experience. Emphasis in instruction is placed upon the prevention of disease, and includes practical measures in control of typhus, malaria, schistosomiasis, dengue, filariasis, plague, cholera and other diseases commonly met in areas of the Pacific where American troops are serving.

## PAMPHLET ISSUED ON REHABILITATION OF BLIND

For the assistance of those charged with the care and rehabilitation of blind patients the Army Medical Department has issued a booklet entitled "Guide for Those Giving Rehabilitation Service to the Blind." Its purpose is to anticipate and answer the questions arising in connection with this type of hospital care. The booklet is intended for use in Army hospitals and centers specializing in Rehabilitation Service for the Blind.

It contains information for those actively engaged in working with the blind, and also for anyone who comes in contact with the blind. The booklet gives valuable hints on the psychology of dealing with this handicapped group.

## COMMENDATION FOR ARMY MEDICAL LIBRARY TRANSLATION SERVICE

The Chief of Laboratory Service at the Army and Navy General Hospital, Hot Springs, Arkansas, recently sent a letter of commendation to the Translation Service of the Army Medical Library which stated in part: "In the past I have had private translation work done for me, but in no instance have I ever received material that could approximate the standard of excellence consistently rendered by the Army Medical Library."

Although the Translation Service of the Library has a staff of only three persons, translations can be made in sixteen languages. These include Russian, Rumanian, Serbian, Czechoslovakian, Ukranian, Turkish, French, German, Norwegian, Swedish, Danish, Italian, Spanish, Portuguese, Dutch and Chinese.

Up to the present, the volume of requests for this service has been so great that it has been limited to the military medical profession only. It is hoped, however, that future expansion will permit the extension of this service to the civilian medical profession as well.

## CURRENT LIST OF MEDICAL LITERATURE

The Adjutant General and The Surgeon General, Major General Norman T. Kirk, have granted permission for the Army Medical Library to take over the publication of the Current List of Medical Literature.

For the last five years this publication has been under the auspices of the Friends of the Army Medical Library and the Medical Library Association. It has rendered a great service in bringing to the attention of the Army Medical Department and the medical profession in general the latest publications in the medical field.

Mr. Ignatius McGuire, formerly in charge of indexing for the Index Catalogue, has been appointed editor of the Current List. Suggestions from consultants or any other interested persons as to the methods of making the List a more useful publication will be welcome.

## GENERAL HAWLEY AND GENERAL CUTLER GO TO VETERANS ADMINISTRATION

Major General Paul R. Hawley, formerly Chief Surgeon of the European Theater of Operations, and Brigadier General Elliott C. Cutler, Chief Medical Consultant with the European Service of Supply, have joined the Veterans Administration staff in Washington, according to a recent announcement of the Office of The Surgeon General.

General Hawley will serve as Medical Adviser to General Omar Nelson Bradley, who recently took office as Administrator of Veterans Affairs. General Cutler will be attached to General Hawley's staff. Both General Hawley and General Cutler have been loaned on a temporary basis to the Veterans Administration.

## MILITARY SURGERY VOLUME PROPOSED

A group of the best manuscripts dealing with military surgery are being compiled by the Surgical Consultants Division of the Office of The Surgeon General for the information of surgical officers in Pacific Theaters of Operation.

The selection of the papers to be used will be made from these that have been prepared by Medical Corps officers and submitted to the Division for review and approval for publication.

It is anticipated, when compilation of the papers is completed, that they will be offset printed and contained in a single volume. Upon completion of the volume it is planned to distribute copies to medical installations in the Pacific.

## Promotions — Changes of Station

Lieut. Comdr. Sidney A. Thompson, (Greenwich) has been promoted to Commander and is assigned to the U. S. Naval Hospital staff at Memphis, Tenn.

Lieutenant Fred H. Zac, (New Haven) AUS has been promoted to Captain and is now with the 194th General Hospital.

Lieutenant Moses Margolick, (Putnam) has been promoted to Captain and is serving with an Auxiliary Surgical Group.

Major Benjamin Simon, (Middletown) has recently been promoted to Lieutenant Colonel. He is executive officer and chief of the neuropsychiatric service at Mason General Hospital, Brentwood, Long Island, New York.

Major Margaret D. Craighill, AUS, (Greenwich) Professional Administrative Service, Chief of Women's Health and Welfare Unit has been promoted to Lieutenant Colonel.

Lieutenant Commanders Philip G. McLellan and William Wilson, both of Hartford, have been promoted to Commander.

Lieut. John J. Narowski, (Derby) has been promoted to Captain, and is stationed with the 235th General Hospital.

Lieutenant Commander Charles C. Montano, USNR, (Hartford) has been promoted to Commander in the Coast Guard. He was recently assigned as medical director of the U. S. Public Health Service and Coast Guard Medical officer of the Seventh Naval District at Miami.

Major John A. DePasquale, AUS, (Hartfrod) has been promoted to Lieutenant Colonel.

## No Parallel

The New York State Journal of Medicine informs us that most Americans cling to the desire for free choice of physicians. Recognizing this as an obstacle to their schemes, the opponents of private medical practice seek to minimize its importance.

Today a favorite method of attacking free choice is to point to the excellent medical service in the Army and Navy. However, this argument bears the seed of its own refutation.

It is true that medical service is excellent in the Army and Navy—being provided for the most part, by the same private practitioners who have made American medical care the best in the world. How many soldiers and sailors, however, would like to carry the military-medical relationship into civilian life?

The men in the armed forces accept the loss of free choice of physicians in the same way as they accept the loss of free choice of residence, food, occupation and working hours—as a necessity born of national emergency. That does not mean they would be willing to relinquish free choice of any of these things permanently—or that its absence is a virtue per se.

## Women Physicians

The U. S. Department of Labor, Woman's Bureau, has published an illustrated bulletin (Bulletin 203, Number 7) entitled Women Physicians. In it attention is called to the fact that the proportion of women physicians to the total number of physicians is lower than the comparable proportions for each of the following professions: teaching, nursing, music and music teaching, social welfare, library service, college teaching, art and art teaching, and editing and reporting.

The bulletin reviews the prewar situation of physicians, wartime changes, and the post war outlook. An appendix contains the usual requirements for entrance to an approved medical school, the requirements for M.D. degree from an approved medical school, the usual requirements for a State license to practise medicine, the requirements for a beginning Federal position as a physician, and the qualifications necessary for women physicians in the Army Medical Corps, in the U. S. Naval Reserve, and in the U. S. Public Health Service.

**MAKING A MOUNTAIN OUT OF A MOLE —**
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

JOSEPH H. HOWARD, *Chairman*, Bridgeport
C. CHARLES BURLINGAME, Hartford
BURR H. CURTIS, Hartford
COLE B. GIBSON, Meriden
ARTHUR B. LANDRY, Hartford

## STATE SOCIETY MEETS WITH VETERANS FACILITY

CONNECTICUT medicine again stepped out in the forefront on September 13 when there was presented for the first time in this country a joint scientific program sponsored by civilian medicine and the veterans administration. Myer Schwolsky, manager of the Newington facility, opened the conference by welcoming the physicians. Joseph H. Howard, president of the Connecticut State Medical Society, presided throughout the session. Captain Howard H. Montgomery, MC—USN, outlined the Navy's program for the treatment of patients as a whole rather than for physical disabilities alone. Captain Maurice Dressler, MC—AUS, discussed the diagnosis and treatment of cardiovascular syphilis. C. Charles Burlingame, chief psychiatrist of the Institute of Living, presented the psychiatric aspects of veteran re-employment. Paul S. Phelps, director of the department of tuberculosis control of the State Tuberculosis Commission, indicated that the post war period will bring increased treatment of tuberculosis patients through improved x-ray equipment and cooperation of Selective Service with civil medical authorities in checking up tuberculosis rejectees. Captain Arthur Grishman, MC—AUS, spoke on the significance and recognition of coronary insufficiency. In the absence of Francis G. Blake, dean of the Yale University School of Medicine, who was being honored that day in Washington as the recipient of the Typhus Medal, Morris Tager of the Yale medical faculty discussed malaria. Dr. Tager in an excellent paper expressed his view that widespread dissemination of malaria in the United States as a result of its incidence among service men is unlikely and declared that atabrine has won its place as an anti malarial drug fully as potent as quinine. Captain J. C. Robbins, DC—AUS, discussed the relation of fluorine to dental caries and pointed to the success of fluorination of drinking water supplies and topical application of fluorine solution to children's teeth in the prevention of tooth decay.

The high spot of the day was reached at the end of the program when Major General Paul R. Hawley, MC—USA, formerly chief surgeon of ETO and now medical advisor to the Veterans Administration presented the need for more beds and personnel to care for the returning disabled veterans. This was Major General Hawley's first appearance outside of Washington in his new capacity as medical advisor to the Veterans Administration. The tremendous needs of veterans hospitals were illustrated by General Hawley who cited the fact that there are currently 10,000 more patients than there are beds in veterans' hospitals and this figure will reach 40,000 by June, 1947. There is a shortage of 1,300 doctors and 600 dentists which represent 25 to 40 per cent deficits on every veterans' hospital staff he said.

General hospitals and neuropsychiatric hospitals were described as the most congested hospital units, and General Hawley pointed to the use of sun porches and recreation rooms for bed space in many of them as harmful to the complete veterans' rehabilitation programs.

Added to the problem of space is that of location of hospitals according to a policy which has placed veterans' hospitals nearest centers of veteran population rather than close to medical centers, thereby increasing the problems of medical personnel, he said. Trained specialists are particularly needed in care of veterans, but doctors furnished to veterans' hospitals by the Army are generally appointed with little regard for the specialties required, it was pointed out.

"It's going to take an awful lot of doing to correct the serious situation which has been built up over the years," the general declared. His primary suggestions were provision for professional opportunities in veterans administration medical service and education of the general public to the necessity of moving veterans to hospital locations where they can receive specialized care rather than keeping them near home where only general medical care may be available. He urged physicians to assist the adminis-

tration in this latter effort, remarking that "nobody can educate a veteran's family like the family physicians."

"We must insist on good full time personnel, and we can't get them without offering them something in the way of a career," he affirmed, and noted that a bill now in Congress providing for a flat 25 per cent increase in salaries for qualified specialists will doubtless serve as an incentive to young medical students to prepare themselves for qualification as specialists.

"We need a keen bunch of young residents with a teaching program operating in every veterans' hospital. Seven such facilities have already been approved for surgical residencies. We need four psychiatric institutes within the Veterans Administration.

"But even if we make it the most attractive service in the world, we're never going to have enough doctors to put specialists in every veterans hospital in the country," he warned. "Therefore, we have to move patients to whatever hospitals are staffed to treat them for special injuries or diseases, and patients' families will have to agree to such procedure."

Among future developments which he "would like to see," General Hawley mentioned residencies in all veterans hospitals which would provide staffs with young men interested in veterans medicine, and the establishment of at least four psychiatric institutions within the veterans administration. "These would contribute to American medicine as well as assist veterans administration problems," he declared.

General Hawley considered the out-patient problem as a most important one which civil doctors can solve, and recommended that medical societies appoint men to be approved by the Veterans Administration for out-patient work with veterans.

## Veterans Administration Contemplates Fellowships in Surgery in Minnesota

On September 13, according to *The New York Times*, the medical advisory board of the American Legion submitted to General Omar N. Bradley, veterans administrator, a tentative proposal to institute the highest type of specialized training for key members of the medical stag of the Veterans Administration facilities.

The proposal grew out of discussions between Dr. L. G. Rowntree, chairman of the American Legion's rehabilitation committee, and officials of the Mayo Foundation, Rochester, Minn., based on a recommendation originally made by the Minnesota department of the Legion.

While the program is tentative until explored by General Bradley, it is believed to be the first concrete suggestion for introducing specialization into the career medical service of the Veterans Administration. The underlying idea is that, if the program is successful, it can be adapted to virtually every State with a postgraduate medical school.

Dr. Rowntree told General Bradley that he had conferred recently with authorities of the University of Minnesota, the Mayo Foundation, the Graduate School of Medicine and the Mayo Clinic, with reference to working out a plan whereby Veterans Administration physicians and surgeons might receive opportunities for special or advanced training.

These officials, he reported, expressed a willingness to take part with the Government in creating a school of training for veterans' doctors, provided such a program would be on a sound educational basis and that the details were worked out to the satisfaction of these institutions and the Government.

Veterans' facilities in Minnesota are scheduled to be increased to a capacity of about 3,000, and it is with special reference to training of doctors and surgeons retained by the Veterans Administration to care for these patients.

Dr. Rowntree suggested to General Bradley that after such work had begun men might be trained in sufficient numbers to enable the Veterans Administration to set up its own training facilities. In the meantime, it was suggested, Fellowships in Surgery could be awarded to members of the administration staff.

Another proposal was that this plan, if successful in Minnesota, might be adapted with set standards to any or all of the forty-three other States in which postgraduate medical study is available.

General Bradley made no commitment on the proposal but was reported to have taken it under advisement for study by his own staff medical advisers and the special medical advisory board of outside specialists set up last spring by Brig. Gen. Frank T. Hines, former Veterans administrator.

Discussion of the plan by the Legion's Advisory Board before it was submitted raised the question whether Civil Service requirements might not have to be amended or waived to make the plan opera-

tive, as the usual postgraduate course extends for three or even four years. Some of the members pointed out difficulty encountered heretofore in arranging for absence from routine work by staff surgeons on the Government payroll for the taking of special studies lasting more than one year.

The possibility also was discussed of working into the plan some arrangement for short, intensive special courses of training for physicians and surgeons, but these alternatives were left without recommendation until the Veterans Administration could have sufficient time to study the broad aspects of the proposal.

## Varied Training Courses Are Planned for Medical Officers

With hostilities ended, medical officers in the armed forces, as well as hospitals and medical schools, have set machinery in motion to repair the holes torn in medical education by the war.

In a comprehenisve review of specific plans to meet the educational needs of returning medical officers, the September 1 issue of *The Journal of the American Medical Association* says that all veterans, regardless of the age at which they entered the service and whether or not they had been in practice, are eligible under the G. I. Bill of Rights for a retraining course of one year at any institution approved by the Veterans Administration.

*The Journal* reports that both the Army and the Navy have already taken steps to provide post war educational rehabilitation of medical officers.

Even before the defeat of Germany, steps were taken by the Army so that officers assigned to field, tactical and administrative positions would be given an opportunity to get a 12-week refresher course in one of the large general hospitals in this country. Many officers returning from overseas are now applying for refresher training.

"It is important," the Navy reports in *The Journal*, "that intensive training be afforded especially to young officers of the regular Medical Corps, who will become the leaders and "key men" later in conducting the medical services of naval hospitals in the long post war period for which provision must definitely be made."

The Council on Medical Education and Hospitals of the American Medical Association reports that an analysis of questionnaires returned by 21,029 medical officers concerning their postgraduate wishes indicates that approximately 20 per cent of this group will desire short term refresher and review courses of less than six months' duration.

Reports from medical schools, hospitals, medical societies and other agencies, *The Journal* says, give assurance of continued expansion of educational programs in anticipation of post war needs.

The University of Wisconsin Medical School has four plans for meeting the desires and needs of physicians returning from military service.

A training plan, termed flexible enough "so that it can start tomorrow morning or at any time a medical officer returns," has been adopted by the medical schools of Duke and North Carolina universities, the Bowman Gray School of Medicine of Wake Forest College and the cooperating North Carolina hospitals.

Three month full time courses have recently been organized by the medical schools of the universities of Wisconsin, Illinois and Iowa.

The Cook County (Chicago) Graduate School of Medicine has plans to accommodate returning medical officers by offering a large variety of courses at frequent intervals.

The University of Michigan Department of Postgraduate Medicine plans three courses of two months each, probably continuing throughout the year.

"Such institutions as Tulane, Johns Hopkins, Harvard, Tufts, New York Eye and Ear Infirmary, the New York Medical College, the New York Polyclinic and the University of Pennsylvania are continuing to offer organized courses," *The Journal* states, adding: "These examples emphasize the fact that, even though the staff physicians of all institutions are sorely taxed, they have been able to develop or continue opportunities for graduate education."

Fourteen state medical societies have initiated or are planning programs of continued education for returning physicians.

"It is becoming increasingly important," *The Journal* says, "that the medical profession and hospitals continue their efforts to maintain and develop adequate facilities and opportunities for the continued training of veteran and civilian physicians."

Under normal peacetime conditions the approved hospitals in the United States provide opportunities for approximately 5,300 resident physicians. *The Journal* estimates that hospitals may be called on to furnish a total of about 12,000 residencies in the immediate post war period.

## Veterans Administration to Establish Mental Hygiene Clinic in Hartford

Because there are insufficient mental hygiene clinics in the Hartford area which will accept discharged veterans, the Veterans Administration has set up in part at Newington a mental hygiene clinic. It is planned in the near future to expand this clinic in the new quarters at 95 Pearl Street, Hartford. All of the out patient treatment now furnished at the Veterans Facility in Newington will be carried out in the Regional Office in Hartford, leaving in patient treatment only for the hospital. Some of the equipment has already been received for the operation of the Hartford clinic.

The personnel of the clinic on Pearl Street will comprise those physicians who have been giving out patient treatment in the hospital at Newington. At present it is planned to have in the mental hygiene clinic one chief neuropsychatrist, one neuropsychiatrist, one psychologist, one case supervisor, and three neuropsychiatric social workers. Other full time physicians in all branches of medicine will be added to this group to care for the increasing numbers of discharged veterans. It is planned to utilize the services of part time physicians if found necessary.

## N. Y. University College of Medicine Starts Program for Medical Officers

New York University College of Medicine has announced a three-point program of graduate and postgraduate education for returning medical officers.

The college also announced it had received a $150,000 three-year grant from the W. K. Kellogg Foundation to help defray the costs of its program for returning medical veterans and to aid in expanding its permanent program of postgraduate medical education.

Revealing that 1,200 graduates of its College of Medicine have been serving in the armed forces—a proportion of service alumni more than twice the national average for all medical schools—New York University anticipates that four-fifths, or some 960, of its graduates on active duty in the armed forces will participate in some type of post war medical instruction.

Announcing the program, Dr. Donald Sheehan, acting dean of the medical college, reported that Dr. Clarence de la Chapelle, assistant dean and professor of clinical medicine, has been placed in charge of postgraduate and graduate education.

Dr. Sheehan predicted the new program would fit the needs of returning physicians who under the G. I. Bill of Rights will be entitled to at least a year's further training in medicine. A questionnaire has been sent to all medical alumni who have graduated since 1920 to ascertain how many intend seeking post war training and the type of course they intend entering.

"It appears obvious," Dr. Sheehan said, "that New York City will become one of the largest postgraduate medical centers of the future. About one-sixth of the approved internships and one-tenth of the residencies in the United States are in hospitals in the metropolitan area.

"New York University College of Medicine will be expected to handle not only a good proportion of its own graduates and former house staff members from its services in Bellevue Hospital, but also a sizeable group of graduates from other schools and countries."

For returning medical officers, the New York University College of Medicine will offer special courses in three classifications:

1. Postgraduate group: A review type of course for officers who were already established in general practice, or in a specialty, and who may have been unable to continue this type of work while in military service. Such courses will range from two weeks to three months, but some will be of six months to one year in duration. Practically every branch of medicine will be included in these courses. Because medical officers will be released at various times from the armed services, the courses will be in continuous operation, with admission at fairly frequent intervals. It is also intended that a physician may be able to review only one or two subjects, or as many as he desires, without waiting long periods between courses.

2. Graduate group: This will include physicians whose postgraduate training was interrupted and who are anxious to complete requirements for certification by the specialty boards. It will also include many who have completed an internship or part or all of a residency. All of these courses will be of long term nature, ranging from one to three years. Fellowships will comprise a fair proportion of them. The basic sciences, taught by clinicians well versed in these fields, will be an integral part of this type of training.

3. Intern group: This, perhaps the most important group from the point of view of the nation's future medical care, according to Dean Sheehan, are those whose medical education and internship were curtailed by the accelerated wartime program and who have simply received too little medical training. This group will remain a year or so in a hospital as an intern or extern to prepare themselves for practice or possibly for a residency in a specialty.

Plans have been submitted by every department of the New York University College of Medicine for "Refresher" or review courses in practically every branch of medicine and surgery, using the facilities of both the Third and Fourth Divisions of Bellevue Hospital and other hospitals affiliated with the medical school, such as Lenox Hill Hospital, Beth Israel Hospital, Irvington House for Cardiac Children, Goldwater Memorial Hospital for Chronic Disease, as well as Manhattan Eye, Ear, Nose and Throat Hospital. Some will begin their programs immediately but most of them will get under way in October.

"It is obvious," Dean Sheehan said, "that the New York University College of Medicine will be called upon to play a major role in the postgraduate training of returning veteran physicians for scarcely anywhere in the world today is there to be found such a wealth of clinical material under the supervision of a single medical school.

"But this plan for post war medical education can be executed only if the armed forces will return many of the key teachers to the medical faculty and hospital staffs."

## Study Shows Brighter Outlook for Victims of Angina Pectoris

The life expectancy after angina pectoris (breast pang) first appears is about twice as long as has been commonly believed, Paul D. White, M.D., Edward F. Bland, M.D., Boston, and Edward W. Miskall, M.D., East Liverpool, Ohio, report in *The Journal of the American Medical Association* for November 27. This statement is based on what is, so far as they know, the first study of this condition that involved a large series of cases followed over an adequate length of time.

The three physicians made a follow-up study in 1943 of 497 cases of angina pectoris that were first observed in the years from 1920 to 1930. Of the 497 patients, they say, "445 are dead and 52 are still living. The average duration to death of the 445 was 7.9 years, while the average duration from onset of the disease in the living is 18.4 years. The average duration to date for the combined dead and living is 9.0 years, which will ultimately increase when all the present survivors succumb, doubtless to a figure approximating ten years, a duration of life about double that at present widely regarded as the expectation of life after angina pectoris first appears [five years or less]. Seventy-six per cent of the deaths were due to cardiac [heart] causes. . . . A pronounced degree of nervous sensibility was a favorable influence [in survival]. Angina pectoris decubitus [an attack coming on while at rest in contrast with one during or immediately following effort] was found in 103 (20.6 per cent) of the 497 cases. There were no significant differences in the average duration of the disease to death or in the living between this group and that of the group as a whole. . . ."

The three men point out that it is not only helpful for the doctor to know something of the average life expectation in general in angina pectoris but also "for the patient himself and for his family, rather than to leave merely the impression that prediction is impossible and that the Sword of Damocles may fall at any moment. Such a state of affairs is for many persons so paralyzing that they are prone to sit for many years awaiting the end, unable to carry on a useful or happy life, or else, hardened by the thought, they may lead a reckless existence which can in truth hasten their end.

YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

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# PUBLIC AFFAIRS

## THE DISTRIBUTION OF HYPNOTICS

HERBERT P. PLANK, *West Haven*

The Author. *Supervisor of the Drug, Devices and Cosmetic Division of the Connecticut Dairy and Food Commission*

SECTION 901e of the 1939 supplement to the general statutes—sub-section K, "A drug or device shall be deemed to be misbranded—If it shall be a drug sold at retail for use by man and shall contain any quantity of amidopyrine, barbituric acid, cinchophen, dinitrophenol or sulfanilamide, or any derivative of any of these substances, unless it shall be sold on a written prescription signed by a member of the medical, dental or veterinary profession who is licensed by law to administer such drug, and its label shall bear the name and place of business of the seller, the serial number and date of such prescription and the name of such member of the medical, dental or veterinary profession. *No such prescription shall be refilled except upon written or oral order of the physician.*"

Section 902e of said supplement—"A drug dispensed on a written prescription signed by a physician, dentist or veterinarian, except a drug dispensed in the course of conduct of a business of dispensing drugs pursuant to diagnosis by mail, shall: If (1) such physician, dentist or veterinarian shall be licensed by law to administer such drugs and (2) such drug shall bear a label containing the name and place of the dispenser, the serial number and date of such prescription and the name of such physician, dentist or veterinarian, be exempt from the requirements of section 901e, *except that no prescription for amidopyrine, barbituric acid, cinchophen, dinitrophenol or sulfanilamide or any derivatives of any of these substances shall be refilled except upon the order of the physician.*"

The wording of the General Statutes may be dull reading for anyone not engaged in enforcing them, but the sections quoted above are of enough importance to the members of the medical profession that they should be read and studied. The words printed in italics, along with the deletion of the words "barbituric acid" from subsection D of the same act, are the changes made by the 1945 General Assembly in an effort to effectively control the distribution of barbiturics without resorting to the increasing demand for putting those hypnotics under the same control as that now exercised over narcotics.

To understand the whole picture it is necessary to review briefly the efforts made in this state to keep the control of hypnotics where it belongs—in the hands of the physicians.

The food, drug and cosmetic act as passed in 1939 mentioned barbiturics in two sections, subsection K as quoted above and in subsection D, where it was included in those drugs whose label must bear the cautionary statement: "Warning—May be habit forming." When those interested in the over-the-counter sale of barbiturics brought this to the attention of the Attorney General, he ruled that there appeared to be a conflict and that barbiturates could be sold over the counter "if properly labeled."

This made it necessary to restrict the control to the prescription of a physician under that section of the law which requires that all labels of drugs sold over the counter bear "adequate directions for use." It was then ruled that no druggist could give adequate dosage directions for such a dangerous drug.

This plan of operation worked with fair success, but there was still some confusion in the minds of the druggists and the changes made by the last General Assembly should remove this confusion. Under these changes the words "barbituric acid" are removed from subsection D on the theory that if these drugs are sold on prescription the habit forming

warning is not necessary. All this leaves barbiturics in the prescription category alone.

Many complaints have been received by this commission on the repeated refilling of prescriptions for hypnotics. It appeared likely that in a large number of these cases the physician who wrote the original prescription would not have approved such refillings and that such refillings without his approval had caused him to lose control of the case. It also appeared likely that many of these refills were for people for whom the prescription had not been written.

The tremendous increase in the number of deaths throughout the country from barbituric poisoning has created a wide demand for more stringent laws regulating their sale and many people believe that they should be placed under the same restrictions as narcotics.

The writer does not believe this to be necessary or advisable. The additions made to our law should take care of the matter if the physician and the druggist will cooperate with us.

The law now provides that these prescriptions cannot be refilled except on the written or oral order of the physician. That means just what it says. If your patient tries to secure a refill of your prescription for barbiturics, or any of the other drugs mentioned in the section, it is the druggist's duty to get in touch with you and ascertain if you want that prescription refilled.

Practically all physicians will, we feel sure, be glad to cooperate with the druggist in this matter, but druggists have reported that some physicians resent being called by them. This may not make sense but apparently such a condition does exist, perhaps because of the rush of the war years.

We believe that you will agree that this "annoyance" is much to be preferred over the far greater burden of the many technicalities which will result if hynotics are placed under the same restrictions as narcotics.

This is our opportunity to avoid such a contingency in Connecticut.

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## Ohio Medical Plan Oversubscribed

Word comes that the $100,000 capital stock issue of the Ohio Medical Indemnity, Incorporated, sponsored by the Ohio State Medical Association, was oversubscribed on August 1.

## Super EMIC Program

What will be the result if S1318 introduced July 26 by Senator Pepper and nine other senators both Democrat and Republican becomes a law in its present form?

Every doctor will continue to support to the utmost the principles and purposes of the best obstetric and pediatric care possible for the mothers and children of America, for American medicine already has done more than any other group to achieve that very end.

But if the bill means:

1. That the Federal government must supply obstetrical and pediatric care irrespective of the individual's ability to pay.

2. That the program is going to be carried out in the same manner as has often characterized the administration of the EMIC program by the Children's Bureau under the Department of Labor.

3. That the medical advisory committee is to have no real power and be so set and made up that the true views of the average individual practicing physician are not given adequate expression.

4. That the initiative in formulating the program will be taken from the individual states and placed in Washington.

5. That the Children's Bureau is to govern by rule, regulation and ukase as has so often marked the EMIC program.

Then the medical profession can be counted upon to oppose this bill just as strenuously and as vigorously as it will oppose many of the features of the Wagner-Murray-Dingell bills or any other proposal to regiment and socialize medicine and the opposition of the medical profession will be as forceful as an atomic bomb.

Consideration of Senator Pepper's measure when Congress convenes some time after September 4 cannot be detached from some of the rumors that loom large in the over-all picture as to what's going to happen to the Children's Bureau which will administer the act if the bill becomes a law in its present form—will the Children's Bureau be transferred from the Department of Labor and put under a new Department of Health and Welfare as the new Secretary of Labor apparently desires? That would have great effect upon the administration of this proposed legislation.

# STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

## THE STATUS OF SEROLOGICAL TESTS FOR SYPHILIS IN CONNECTICUT: A REPORT TO CONNECTICUT PHYSICIANS

EARLE K. BORMAN, M.S., and FRIEND LEE MICKLE, M.S., SC.D., *Hartford*

Mr. Borman. *Assistant Director, Bureau of Laboratories, Connecticut State Department of Health, Hartford*

Mr. Mickle. *Director, Bureau of Laboratories, Connecticut State Department of Health, Hartford*

THIS REPORT is being made because the efficiency of serological testing for syphilis in state, city, hospital, institutional and private laboratories in Connecticut is a matter of very real interest to the medical profession. The work reported is largely the result of recommendations made to the State Department of Health by the Public Health Committee of the Connecticut State Medical Society and by an Advisory Committee for Statewide Evaluation Studies of Serodiagnostic Laboratories appointed to counsel and guide the department in carrying out the original recommendations.

### THE PROBLEM

The diagnostic problems of syphilis are many and varied. In seeking to resolve these problems the medical profession must rely heavily upon laboratory aids, in particular upon serological tests. A serological test for syphilis may be performed by any one of a number of different methods, many of which are in use in one or another of about 50 laboratories in Connecticut under conditions which vary widely among different laboratories. In one laboratory the person performing the test may have the highest qualifications while in another laboratory a relatively inexperienced worker may be entrusted with the performance of these exacting tests. Obviously, the standard of performance will vary widely among laboratories unless some effort is made to promote uniformity of methods and testing conditions and to provide a means whereby each laboratory may evaluate its own performance record in comparison with the records of others. The providing of these factors has been the aim of the activities outlined in this report.

### LINES OF ATTACK

#### EARLY COMPARISONS OF TESTS FOR SYPHILIS

Early efforts to determine the respective merits of different tests for syphilis were international and were sponsored by a committee of the Health Organization of the League of Nations.[1,2,3] While these studies emphasized the discrepancies among the various tests, their main value was in washing out some very poor techniques. Only one test now in general use in the United States was entered in those studies. Many techniques were proved inadequate or non-specific. Those studies are now of little more than historical interest except that they did suggest to later investigators a plan whereby one test might be compared with others.

#### AUTHOR EVALUATION STUDIES IN THE UNITED STATES

Late in 1934 a detailed plan was announced[4] for evaluating different tests for syphilis under the auspices of the United States Public Health Service. Under this plan replicate blood specimens identified by number only were sent to laboratories of the various authors of tests or to their representatives for testing. Specimens were taken from individuals with syphilis, from non-syphilitics in normal health and from febrile and afebrile non-syphilitic patients suffering from other conditions. The results of this study were published[5] in 1935. A later, more inclusive study[6] was planned and finished in 1941. This study was so organized that authors of tests or representatives of their choosing were brought to Washington and given replicate specimens for testing in separate laboratories under one roof.

These studies have had a beneficial effect upon serological work in the United States. A number of inadequate tests have been discarded and tests which

survived the evaluations have been adopted in their stead. It has become general practice to regard the successful tests as "standard." Among these standard tests the following are now in use in Connecticut: Mazzini flocculation test, standard Kahn test, Eagle flocculation test, Kline diagnostic and exclusion tests, Hinton test, Kolmer complement-fixation test and Connecticut complement-fixation test.

Many persons express concern that there is still a multiplicity of tests which are regarded as standard. It should be recognized, however, that any one of the several standard tests properly performed is satisfactory for confirming a diagnosis of untreated syphilis. Discrepancies among standard tests are rarely encountered after the initial seronegative stage until treatment has suppressed the blood reactivity to a near threshold level. This is sometimes possible when treatment has been inadequate to protect against relapse. However, even though certain tests are more sensitive than others on the average, it is not possible to predict just which test or tests will first become negative on an individual who is undergoing treatment.

### EVALUATION OF STATE DEPARTMENT OF HEALTH LABORATORIES

Following the first evaluation of author serologists in the United States, nationwide studies of the efficiency of serologic testing in state laboratories have been conducted annually by the United States Public Health Service. The first of these,[7] in which Connecticut was not asked to participate, was conducted in 1936. Results of participation of the Bureau of Laboratories in the 1937, 1938 and 1939 studies have been discussed previously.[8,9,10] Detailed reports on Connecticut's performance in subsequent studies have not been published but were made available to the State Department of Health for study which has proved helpful in improving the serodiagnostic servcies of the Bureau of Laboratories.

These annually conducted interstate studies have been of immense value in improving the serological service rendered to physicians throughout the United States. In addition, the way was prepared for state laboratories to take the next logical step—the extension of evaluation studies to local laboratories on a statewide basis.

### EVALUATION OF LOCAL LABORATORIES

Coincidental with the early nationwide evalution studies an Assembly of Laboratory Directors and Serologists was held at Hot Springs, Arkansas, October 21-22, 1938, which was attended by representatives of the Connecticut State Department of Health. The proceedings[11] of this assembly covered many aspects of the laboratory problems involved. Particularly significant items were (1) the adoption of a recommendation that evaluation studies be extended within each state to local laboratories and (2) the creation of standards by which laboratory performance should be judged in evaluation studies. During 1940 the Public Health Committee of the Connecticut State Medical Society, upon recommendation of Dr. Maurice J. Strauss of New Haven, a member of that Committee, urged the State Department of Health to undertake such a statewide evaluation study. This was done during 1940-1941 with funds made available through a federal grant-in-aid, under the guidance of an advisory committee so appointed as to be representative of the interests of the State Medical Society; local health officials; hospitals and state institutions; laboratory directors and pathologists; practicing physicians (especially syphilologists and dermatologists); and other interested groups. Results of that study clearly indicated the need for improvement of serological testing throughout the state. The State Department of Health undertook to accomplish this by urging strict conformity to laboratory techniques as published[12] by the authors of the tests used and by adopting more stringent standards for the approval of serodiagnostic laboratories. Funds to continue the evaluation studies after the 1940-1941 study were not again available until specific appropriations were obtained for the 1943-1945 biennium. A complete survey was made of all serodiagnostic laboratories during the spring of 1944 and a third statewide evaluation study was conducted by evaluating one half of the local laboratories in two surveys made in the fall of 1944 and the spring of 1945. During these studies the Advisory Committee* has continued to advise the Department at semi-annual meetings and has been most active in recommending courses of action.

*Currently composed as follows: Robert Agnew, M.D., Norwich; Creighton Barker, M.D., New Haven; Harriet Bixby, M.D., Middletown; Paul H. Brown, M.D., Stamford; Jessie W. Fisher, M.D., Middletown; Louis P. Hastings, M.D., Hartford; F. Earle Kunkel, M.D., Hartford; Alfred Labensky, M.D., New London; Richard J. Lawton, M.D., Waterbury; Friend Lee Mickle, SC.D., Hartford; Paul D. Rosahn, M.D., New Britian; Daniel E. Shea, M.D., Hartford; George H. Smith, PH.D., New Haven; Maurice J. Strauss, M.D., New Haven; Henry P. Talbot, M.D., Hartford; Ellwood C. Weise, M.D., Bridgeport; Stanley H. Osborn, M.D., Hartford, Chairman.

## The Current Situation

### NATIONAL EVALUATION STUDY (1945)

Inasmuch as the success of any statewide program to improve serological testing for syphilis must depend in large measure upon the quality of test performance in the laboratory of the state department of health, this section of the report would not be complete without some mention of the current performance ratings of the Bureau of Laboratories. Those ratings on the tests performed in the 1945 National Evaluation Study compared with performance ratings for laboratories of author serologists, with ratings for federal research laboratories and with average ratings for other state laboratories are given below.

In the study replicate specimens were submitted to all participating laboratories from 200 syphilitc donors, mostly treated, and from 153 presumably non-syphilitic donors in good health. Sensitivity ratings were calculated from results on syphilitic donors by adding together the percentage of negative reactions and one half the percentage of doubtful reactions. A specificity rating of 100 means that no false reactions were obtained.

| COMPLEMENT FIXATION TESTS | SENSITIVITY | SPECIFICITY |
|---|---|---|
| Bureau of Laboratories | | |
| Connecticut Complement Fixation Test | | |
| Serologist X | *81.4* | *100.* |
| Serologist Y | *73.8* | *100.* |
| Kolmer simplified Complement Fixation Test | *80.4* | *100.* |
| Dr. Kolmer's Laboratory | | |
| Simplified Kolmer | 78.3 | 98.6 |
| Quantitative Kolmer | 75.7 | 97.6 |
| Dr. Eagle's Laboratory | | |
| Eagle Complement Fixation Test | 75.8 | 99.3 |
| Venereal Disease Research Laboratory | | |
| Kolmer simplified | 78.4 | 100. |
| Hot Springs Laboratory | | |
| Kolmer simplified | 82.5 | 100. |
| Average of other state laboratories | | |
| Kolmer Complement Fixation Test (23 laboratories) | 78.0 | 99.7 |
| Eagle Complement Fixation Test (3 laboratories) | 74.6 | 99.3 |
| Other Complement Fixation Tests (5 laboratories) | 78.5 | 100. |

| EAGLE FLOCCULATION TEST | | |
|---|---|---|
| Bureau of Laboratories | *82.6* | *100.* |
| Dr. Eagle's Laboratory | 81.2 | 100. |
| Venereal Disease Research Laboratory | 80.1 | 99.7 |
| Average of 4 other state laboratories | 82.5 | 99.7 |

| HINTON TEST | | |
|---|---|---|
| Bureau of Laboratories | *81.7* | *100.* |
| Dr. Hinton's Laboratory | 81.6 | 100. |
| Venereal Disease Research Laboratory | 79.6 | 100. |
| Average of 10 other state laboratories | 79.7 | 99.6 |

| KAHN TEST, STANDARD | | |
|---|---|---|
| Bureau of Laboratories | *82.9* | *100.* |
| Dr. Kahn's Laboratory | 77.7 | 100. |
| Venereal Disease Research Laboratory | 78.8 | 100. |
| Average of 33 other state laboratories | 75.0 | 99.7 |

| KLINE DIAGNOSTIC TEST | | |
|---|---|---|
| Bureau of Laboratories | *81.9* | *100.* |
| Dr. Kline's Laboratory | 76.5 | 100. |
| Venereal Disease Research Laboratory | 69.9 | 100. |
| Average of 16 other state laboratories | 78.5 | 99.8 |

| KLINE EXCLUSION TEST | | |
|---|---|---|
| Bureau of Laboratories | *84.5* | *100.* |
| Dr. Kline's Laboratory | 82.5 | 100. |
| Venereal Disease Research Laboratory | 82.1 | 98.7 |
| Average of 4 other state laboratories | 84.4 | 99.2 |

| MAZZINI FLOCULATION TEST | | |
|---|---|---|
| Bureau of Laboratories: | | |
| Serologist X | *82.1* | *100.* |
| Serologist Y | *78.3* | *100.* |
| Mr. Mazzini's Laboratory | 84.0 | 99.7 |
| Venereal Disease Research Laboratory | 79.5 | 99.4 |
| Average of 14 other state laboratories | 81.4 | 99.1 |

The ratings given are compiled from data submitted by the United States Public Health Service to all participating state health departments.

A brief study of the results shows that the performance of the several tests in the Bureau of Laboratories was highly satisfactory during the period of the study reported. Not a single false reaction was obtained in any of 10 performances of 8 tests and the sensitivity level of all tests was of a high order (for most tests, better than ratings in the author's own laboratory).

### STATEWIDE EVALUATION STUDIES (1944-1945)

As mentioned previously, two statewide evaluation studies have recently been completed—one during the Spring of 1944, and one partly in the Fall of 1944 and partly in the Spring of 1945. In these studies the general plan was the same as that described for the national studies discussed above. However, by vote of the Advisory Committee, standard antigens for use in the two studies were furnished to each laboratory so that one possible variable would be removed when considering results. Each participating laboratory received portions of the same specimens, approximately 30 from syphilitic donors and 30 from non-syphilitic donors. Donors having well authenticated histories were

chosen by members of a sub-committee. The Venereal Disease Research Laboratory of the United States Public Health Service served as the control laboratory for both studies and the Bureau of Laboratories also participated.

In the 1944 spring study 48 local laboratories participated. Among these, 21 performed at least one test satisfactorily while 27 (56.3 per cent) were sub-standard (3 were very poor). Much follow-up work was done by the State Department of Health in an attempt to correct bad situations where found. Serologists from some local laboratories were requested to come to the Bureau of Laboratories for instruction and qualified serologists from the Bureau visited other laboratories to demonstrate correct techniques.

During the 1944-1945 study, 49 local laboratories were evaluated. Thirty-five performed at least one test acceptably; 14 (28.6 per cent) were sub-standard (3 were poor). This study showed that considerable improvement in test performance had occurred. Follow-up work on this study is still going on although much has been accomplished. The following sections are devoted to discussion of this work.

### CERTIFICATION OF SEROLOGISTS

Following the completion of the first half of the 1944-1945 Statewide Evaluation Study, the Advisory Committee at a meeting held to study the results discussed thoroughly the problem of what to do about poor serology in a laboratory not approved by the State Department of Health but free to operate as a "registered" laboratory. The Committee recommended a proposed revision of Regulation 40-B of the Sanitary Code to the Public Health Council of the State Department of Health for consideration and the Public Health Council passed the proposed revision to become effective on July 1, 1945. Under the regulation a serologist, before performing a test for syphilis, must hold a certificate from the State Department of Health stating that he or she has demonstrated proficiency in performing the test. Certain exemptions for research and instructional purposes are included as well as provision for exemption of a laboratory operated by a physician exclusively for use in his own private practice.

To enforce this regulation certain requirements and standards have been placed in force by the Department. These place certification upon the basis of (1) satisfactory participation in a national or a statewide evaluation study or (2) satisfactory demonstration of proficiency in performing a specified test before a representative of the Department. Certificates must be renewed annually and are subject to revocation for cause.

The immediate problem before the Department was that of assuring to physicians the uninterrupted services of laboratories which had not already qualified in evaluation studies by providing means whereby serologists could obtain instruction and experience. How this was accomplished is detailed below.

### TRAINING AND EXAMINATION OF SEROLOGISTS

Many laboratories—particularly those not associated with venereal disease clinics—do not have sufficient specimens from treated cases of syphilis to provide adequate experience in detecting intermediate reactions to the tests. For that reason and also because many laboratories were having difficulty in obtaining experienced serologists under war conditions, the facilities of the Bureau of Laboratories were made available for training of serologists in local laboratories in two ways:

1) By appointment to review the technique of a given test for a sufficiently long period of time depending upon difficulties experienced, and

2) By the more formal method of providing short intensive courses of instruction at a "serology school" devoting a week to each of the standard tests.

The first method seemed the more desirable one for serologists with considerable experience who were having minor difficulties while the latter method was developed particularly for those with little experience but was made available to all who wished to take advantage of the opportunity. Funds were made available in the war budget of the Department to pay transportation and reasonable living expenses for those coming to Hartford for instruction. By vote of the Public Health Council, workers in commercial laboratories, however, were required to defray these costs themselves.

The series of courses given included one week each of instruction in the standard Kahn test, the Kline diagnostic test and complement-fixation tests. Two weeks of instruction in the Mazzini flocculation test were necessitated by a large enrollment for that test. No applications for instruction in other tests were received although it had been offered. Courses consisted of an orientation lecture on the limitations of tests for syphilis in general and of the test under discussion in particular, followed by demonstration of correct technique of performing

the test and intensive supervised practice for each individual in preparing reagents, performing the test and reading results. At the end of the course each student was given a practical examination in the form of a demonstration of ability to perform the test on a series of selected specimens varying widely in reactivity as compared with the results obtained by the examiner on the same specimens. The practical work was under the supervision of the chief serologist.

### QUALIFIED SEROLOGISTS

There are now 121 serologists who have received certificates from the State Department of Health authorizing them to perform specified serological tests for syphilis undre Regulation 40-B of the Sanitary Code. Sixty-five qualified by acceptable performances in evaluation studies; 40, by demonstration of proficiency before an examiner; 8, by passing examinations following the courses of study outlined above; 8, by combinations of these methods. Other applications are still pending.

The qualified serologists are distributed as follows: 66 in 25 hospital laboratories; 12 in 5 city or town health departments; 11 in 6 state hospitals and tuberculosis sanatoriums; 9 in 7 private commercial laboratories; 9 in the State Department of Health; 7 in 3 federal establishments; 6 in 4 industrial medical laboratories; 1 resigned worker, now out of the state. No laboratory approved by the State Department of Health for premarital and prenatal blood tests is without a certified serologist and several laboratories not approved for that purpose have certified serologists on their staffs.

## The Immediate Future

Further improvement can be effected in the performance of tests for syphilis in local laboratories. The fine spirit of cooperation which has been shown by both directors and personnel of those laboratories is the surest index that efforts will continue to be successful. Proposed and possible steps to further this end are given below.

### PROPOSED 1945-1946 STATEWIDE EVALUATION STUDY

It is desirable to conduct a fourth statewide evaluation study of about 50 local laboratories. This will have to be done in two parts, one in the fall of 1945 and the other in the spring of 1946. This projected study should serve as a yardstick for the measurement of improvement effected by the certification program and should bring out any errors that may have been made in initiating the program. The results should have considerable significance and there is reason to believe that the standard of performance will be still more greatly improved.

Some members of the Advisory Committee are convinced that statewide evaluation studies may not have to be carried out annually if the certification plan proves successful. It may, however, prove advisable to conduct these at longer intervals. A possible substitute is the submission at unannounced times of a series of check specimens to each laboratory. This series would consist of serums graded in reactivity and would include clear-cut negative serums. The latter plan is under consideration.

### DISTRIBUTION OF STANDARDIZED REAGENTS

The Advisory Committee has advised the State Department of Health on several occasions that a great step forward would be made if the Department could find means whereby reagents of tested merit for tests for syphilis would be distributed to local laboratories at cost price. This recommendation has been given added weight by results in the last two evaluation studies. Several serologists receiving good performance ratings with standard antigens obtained inferior results on the same specimens with antigens of commercial origin used routinely in their laboratories. A plan to initiate this service is under consideration at present.

### TRAINING AND EXAMINATIONS OF SEROLOGISTS

The enthusiasm of the trainees in the "serology school" mentioned above and the improvement in technique demonstrated by them after completing the course have been gratifying. No matter what the formal training of a serologist may have been, it is our firm opinion based upon repeated observations that ability to detect and read varying degrees of reactivity in serological tests for syphilis can be gained only under supervised instruction in a laboratory handling large numbers of specimens from treated cases. Thus, it is in large measure a responsibility of this Department to offer its facilities for advanced training of those serologists who have satisfied other qualifications for positions in local laboratories. The training program will be continued so long as funds and personnel are available to do the job. The examination of serologists is an ancillary and necessary part of that program as well as of the requirements of Regulation 40-B of the Sanitary Code.

### RENEWAL OF SEROLOGISTS' CERTIFICATES

The certification of serologists under the provisions of the Sanitary Code calls for annual renewal. It is necessary that some sound basis be found for

re-issuing certificates. The plan eventually devised must have a certain measure of flexibility. The following possibilities are under consideration as requirements for annual renewal:

1) Satisfactory participation in a statewide evaluation study within two years previous to the renewal date.

2) Satisfactory performance of tests comparable to that in a control laboratory on specially selected specimens submitted for the purpose at any time as deemed necessary but at least once every two years.

3) Satisfactory demonstration of continued ability to perform the test by review of test records or by practical examination, either to be conducted by a representative of the State Department of Health as deemed necessary but at least once every two years.

STANDARDIZATION OF TESTS

In a previous section, mention has been made of the multiplicity of standard tests for syphilis available for use. In Connecticut different laboratories use different tests. There are at present 9 tests in routine use throughout Connecticut laboratories which may be grouped into 4 categories as follows: 2 diagnostic slide flocculation tests; 3 diagnostic tube flocculation tests; 3 complement-fixation tests; 1 supersensitive ("screen") slide flocculation test. In the near future it is hoped that one of the complement-fixation tests and the supersensitive slide flocculation test will be discontinued by the laboratories using them, thus reducing the number of tests to 7, all standard diagnostic tests.

The type of service rendered by a laboratory should to a large extent determine the type of test selected for use. For example, in a small hospital there is little reason for performing serological tests except those on specimens from transfusion donors when the tests are frequently required "stat". The requirements of that situation call for the use of a relatively rapid test and usually a sensitive slide flocculation test is selected. In a larger laboratory capable of performing a somewhat larger volume of serological work with no or few emergency calls, a tube flocculation test permits the easy and economical interlocking of serological tests with the time devoted to other work. In laboratories where a very large volume of work is handled by specialized personnel, it is desirable to perform two different types of tests, one a flocculation test and the other a complement-fixation test. In such a laboratory the dictates of time and labor may make it advisable to choose a slide flocculation test in preference to a tube flocculation test. The so-called "supersensitive" flocculation tests have not proved sufficiently more sensitive than certain diagnostic tests to merit continuance.

Obviously, much confusion would be eliminated automatically if 3 different types of tests (1 slide flocculation, 1 tube flocculation and 1 complement-fixation) were available which would yield closely comparable results on the same specimen, whether or not taken from a treated individual. This is not the case at present but the need for uniform quantitative serology required as a clinical guide to the use of penicillin therapy will probably spur efforts to reach this desirable end. Until that time it seems inadvisable to attempt to limit the selection of tests beyond insisting that those used be standard in the sense that they have been found satisfactory in an author serologist evaluation study conducted by the United States Public Health Service.

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# SPECIAL NOTICES

## EIGHTEENTH GRADUATE FORTNIGHT OF THE NEW YORK ACADEMY OF MEDICINE OCTOBER 8 TO 19, 1945

Subject of this Fortnight: "Contributions of the War Effort to Medicine."

Except for men in uniform, admission will be by registration card only. Fellows of The New York Academy of Medicine will be furnished registration cards without application. For others, a registration card willl be sent upon receipt of check for five dollars, payable to The New York Academy of Medicine. The Scientific Exhibit is open to all physicians and medical students. Hours 10 A. M.—11 P. M.

### Evening Sessions — 8:30 o'clock
### The New York Academy of Medicine

MONDAY, OCTOBER 8

Address of Welcome
Cornelius P. Rhoads, acting president, The New York Academy of Medicine

Scientific Program

1. The Ludwig Kast Lecture[1]
   Modern concepts of war neuroses
   William C. Menninger, Colonel, MC—AUS
2. What can the practitioner do in treating the neuroses?
   Thomas A. C. Rennie, Associate Professor of Psychiatry, Cornell University Medical College

TUESDAY, OCTOBER 9

1. Sedation as a technique in psychotherapy
   Roy R. Gringer, Lieutenant Colonel, MC—AUS, Medical Executive of the Don Ce-Sar Convalescent Hospital, St. Petersburg, Florida
2. Planned convalescence
   Howard A. Rusk, Colonel, MC—AUS, Chief, Convalescent Services Division, Office of the Air Surgeon

WEDNESDAY, OCTOBER 10

1. Physiological and psychological effects of bed-rest
   David P. Barr, Professor of Medicine, Cornell University College of Medicine
2. Evaluation of early postoperative activity
   John H. Powers, acting surgeon-in-chief, The Mary Imogene Bassett Hospital, Cooperstown, New York
3. Discussion
   Allen O. Whipple, Valentine Mott Professor of Surgery, College of Physicians and Surgeons, Columbia University

1. In memory of Dr. Ludwig Kast who proposed the Graduate Fortnight

THURSDAY, OCTOBER 11

1. The use of human serum albumin in the treatment of edema of renal and hepatic origin
   George W. Thorn, Hersey Professor of the Theory and Practice of Physic, Harvard Medical School
2. The plasma globulins in prophylaxis and treatment
   Joseph Stokes, Jr., William H. Bennett Professor of Pediatrics, School of Medicine, University of Pennsylvania

FRIDAY, OCTOBER 12

1. Mechanism of shock
   Dickinson W. Richards, Jr., Professor of Medicine, College of Physicians and Surgeons, Columbia University
2. Management of blood preservation and blood substitutes
   S. Howard Armstrong, Associate in Medicine and Research Associate in Physical Chemistry, Harvard Medical School

MONDAY, OCTOBER 15

1. The Carpenter Lecture[2]
   Treatment of peripheral arterial injuries
   D. C. Elkin, Colonel, MC—AUS, Chief of Surgical Service, Ashford General Hospital, White Sulphur Springs, West Virginia (Whitehead Professor of Surgery, Emory University, on leave of absence)
2. Thrombosis and embolism
   Arthur W. Allen, Lecturer in Surgery, Harvard Medical School; Chief of East Surgical Service, Massachusetts General Hospital

TUESDAY, OCTOBER 16

1. Reconstructive surgery of nerves
   T. I. Hoen, Lt. Comdr., MC—USN, St. Albans Hospital
2. Reconstructive surgery of the joints
   Philip D. Wilson, Surgeon-in-Chief, Hospital for Special Surgery
3. New absorbable hemostatic agents
   Virginia Kneeland Frantz, Assistant Professor of Surgery, College of Physicians and Surgeons, Columbia University

WEDNESDAY, OCTOBER 17

1. The use of penicillin and streptomycin in surgical infections
   Jonathan E. Rhoads, Assistant Professor of Surgical Research, and Associate in Surgery, School of Medicine, University of Pennsylvania
2. Chemotherpy in malaria
   James A. Shannon, Associate Professor of Medicine, New York University College of Medicine

2. In memory of Dr. Wesley M. Carpenter

THURSDAY, OCTOBER 18

1. Nutritional needs in acute and chronic illness
   John P. Peters, John Slade Ely Professor of Internal Medicine, Yale University, School of Medicine
2. Re-evaluation of the vitamins
   L. Emmett Holt, Jr., professor of pediatrics, New York University College of Medicine

FRIDAY, OCTOBER 19

1. The stimulus of war to cardiology
   Robert L. Levy, Professor of Clinical Medicine, College of Physicians and Surgeons, Columbia University
2. Filariasis
   H. W. Brown, Professor of Parasitology, College of Physicians and Surgeons, Columbia University

## MORNING PANEL DISCUSSIONS

Morning Panel Discussions will be held at the Academy as shown in the following schedule. Fellows of the Academy and registrants are invited to attend and participate. It is requested that questions for discussion be submitted in advance of the conference to Dr. Mahlon Ashford at the Academy, or, if this is not feasible, they may be submitted in writing to the Chairman during the discussion.

TUESDAY, OCTOBER 9, 11:00-12:30 A. M.

Subject: Psychiatric rehabilitation

Chairman: Thomas A. C. Rennie

Members: Sol Weiner Ginsburg
Roy R. Grinker, St. Petersburg
Lawrence S. Kubie
William Menninger, Colonel, MC—AUS
Howard A. Rusk, Colonel, MC—AUS

FRIDAY, OCTOBER 12, 11:00-12:30 A. M.

Subject: Physical reconstruction

Chairman: William Benham Show

Members: Carl Binger
John R. Cobb
Edward Hockhauser
Raymond Hussey, Detroit
J. Masur, Washington

TUESDAY, OCTOBER 16, 11:00-12:30 A. M.

Subject: Vascular surgery

Chairman: D. C. Elkin, Colonel, MC—AUS

Members: William Andrus
Arthur Blakemore
Alfred Blalock, Baltimore

FRIDAY, OCTOBER 19, 11:00-12:30 A. M.

Subject: Ununited fractures

Chairman: Philip D. Wilson

Members: David Bosworth
William Darrach
George Carpenter, Lt. Colonel, MC—AUS
T. C. Thompson, Lt. Colonel, MC—AUS

Afternoon hospital clinics will be held daily from 2:00 to 5:00 P. M. There will be a scientific exhibit, motion picture demonstrations, a drug clinic, and a special exhibition of books during the Fortnight.

## CONNECTICUT COLLEGE OF PHARMACY ANNIVERSARY

Connecticut Pharmacy will celebrate the Twentieth Anniversary of the Connecticut College of Pharmacy on October 11 and 12. As befitting the commemoration of the College of Pharmacy Anniversary, the program will be in the nature of a professional clinic or seminar. This marks the first twentieth anniversary of a college of pharmacy in New England. Some of the country's foremost authorities on medicine and science will visit Connecticut to help us celebrate the event. Following is a list of the scheduled speakers:

*Dean Henry S. Johnson*, University of Connecticut, College of Pharmacy: "Twenty Years at Our College."

*Dr. A. N. Jorgensen*, President of University of Connecticut: "Pharmacy's Place in Our University."

*Mr. E. Walter Bobst*, President, Hofman-LaRoche, Nutley, New Jersey: "What a Pharmacist Should Know About Hormones."

*Professor Nicholas Fenney*, University of Connecticut, College of Pharmacy: "Discussing Advances in Pharmacy Specifically for Returning Servicemen."

*Dr. Stanley H. Osborn*, State Commissioner of Health: "What the Pharmacist Has Meant to the Health and Welfare of the People of the State of Connecticut."

1. Control of narcotics.
2. Control of barbiturates.
3. Cooperation with Dairy and Food Commission.
4. Treatment of V. D.??

*Mr. Ray Schlotterer*, Exceutive Secretary of Federal Wholesale Druggists' Association, New York City: "Plan Today for Tomorow's World."

*Dr. James Raglan Miller*, Gynecologist, Hartford: "Hormones in Gynecology."

*Dr. C. H. Mann*, E. R. Squibb & Son: "Trends in the Development of Therapeutic Agents" (this talk will be supplemented by slides).

*Dan Rennick*, Editor, *Drug Topics*: "The Future."

*K. Pierre Dozois, Ph.D.*, Director of Sales Education, Wyeth, Inc., lecturer and writer: "A New Therapeutic Horizon"—Penicillin—Anti-biotics.

*Anna Griffin, R.N.*, President, Connecticut Registered Nurses' Association: "What the Pharmacist Means to the Hospital."

*Frank F. Law*, Vice-President, Wyeth, Inc., Trustee of Temple University School of Pharmacy: "Greetings from Temple University."

*Mayor John Murphy*, of New Haven: "Official Greetings from New Haven."

*Dr. Ernst Boris Chain*, Brilliant Research Chemist, representing Great Britain's Medical Research Council. Member of the original team recruited from the Oxford faculty by Dr. Florey to further penicillin research. We quote, J. D. Radcliff in his book Yellow Magic, "A. D. Gardner was assigned to handle the bacteriological investigations. Norman Heatley and A. G. Sanders grew the microbes. M. A. Jennings served as biologist. For his chemists, Florey selected E. P. Abraham and Dr. Ernst Boris Chain. If this stellar team had any first magnitude star, it was probably Chain, a brilliant Berlin-born Jew."

Dr. Chain is at present in the United States to discuss the various phases of penicillin activity with medical authorities in this country.

*F. B. Peck*, M.D., Associate Director, Medical Division, Eli Lilly. His subject will be: "Insulin and the Newer Forms of Insulin."

### PHYSICIANS NEEDED IN CHINA

The Chinese Government has requested UNRRA to provide, as soon as possible, some 200 field personnel of the following categories to strengthen the available Chinese personnel. Such personnel will be required to head the respective services in hospitals of 100 or 250 beds, which will be established in areas recently liberated from the Japanese.

General Surgeons
Orthopedic Surgeons
Genito-Urinary Surgeons
Gynecologist and Obstetricians
General Physicians
Dermatologists and Syphilologists
Ophthalmologists
Otolaryngologists
Radiologists
Dentists
Pediatricians
Laboratory Technicians
X-ray Technicians
Sanitary Engineers
Public Health Engineers
Public Health Nurses
Clinical Nurses

General practitioners with some specialist experience will be acceptable. Candidates should be under 55 years of age and in good physical condition.

Will those interested please write to me at UNRRA, 1344 Connecticut Avenue, N. W., Washington 25, D. C.

Yours sincerely,
Szeming Sze, M.D.,
Chief, Far East Section
Health Division

## Corneal Transplant Operation Centers Established

Centers for corneal transplant operations on suitable cases have been established at Valley Forge General Hospital and Dibble General Hospital. Suitable cases will be sent to these centers.

# WOMAN'S AUXILIARY
## TO THE CONNECTICUT STATE MEDICAL SOCIETY

### Fall Meeting Cancelled

The Board of Directors of the Woman's Auxiliary of the Connecticut State Medical Society held a meeting on Wednesday, September 12 at 1:30 at the Hunt Memorial Building, 38 Prospect Street, Hartford. The Board voted to cancel the semi-annual meeting scheduled for September 26 since the Clinical Congress of the Connecticut State Medical Society could not be held this year. Plans were discussed for a semi-annual meeting later in the fall and notices will appear as soon as the plans are completed.

Members of the Advisory Committee of the Woman's Auxiliary present at the meeting were Ralph L. Gilman, E. Myles Standish, Martha L. Clifford and John D. Booth.

### Windham County

The fall meeting of the auxiliary will be held at the Russian Bear in Thompson on October 18, at 12:30 o'clock. It will be a luncheon meeting. Dr. Creighton Barker of New Haven will speak on the subject of "Tax Supported Medicine." Mrs. David Bates of Woodstock and Mrs. Andrew Laakso of Putnam have been a committee of two in charge of making the arrangements for this meeting.

A meeting of the Executive Committee of the Auxiliary was held on September 11 at the home of Mrs. Bates in Woodstock to complete plans for the fall meeting and to discuss further plans of the Auxiliary.

**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)



**MAKING YOUR WISHES COME TRUE . . .**

One wish has been fulfilled. Won by 3½ years of deadly struggle. With God's help, we have prevailed.

Now we have a chance to make another wish come true. For most of us, the outlook is a bright one. If we will simply use the brains, the will, the energy, the enterprise . . . the materials and resources . . . with which we won our war, we can't fail to win the peace and to make this the richest, happiest land the world has known.

Your wishes have been wrapped in that bright outlook. Your wish for a cottage by a lake. For your boy's college education. For a trip you long to take. For a "cushion" against emergencies and unforeseen needs.

You can make those wishes come true by buying bonds today . . . buying them regularly . . . and holding on to them in spite of all temptation.

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So why not be patriotic and smart at the same time?

**FULFILL YOUR WISH—BUY EXTRA BONDS IN THE GREAT VICTORY LOAN!**

# OUR NEIGHBORS

## Dean Clark Medical Director of N. Y. Health Insurance Plan

The Health Insurance Plan of greater New York (HIP), announced by Mayor LaGuardia in April 1944, is reported by *New York Medicine* to have taken on a new lease of life through the appointment of Dr. Dean A. Clark as medical director.

HIP proposes to cover New York City and several suburban counties with a program offering full medical and hospital services for workers and their families earning up to $5,000 a year. It is expected to be financed by a four per cent payroll contribution shared equally by employers and employees.

Although extended conferences were held last fall and winter with representatives of the medical profession throughout the city, there still remain many administrative arrangements and details to be worked out. It appears that HIP will concentrate upon provision of medical services under group practice arrangements to be developed in cooperation with leading hospitals and medical centers. Coverage will include physicians' services in homes, offices and hospitals as well as diagnostic and consulting services,—with the exception of chronic functional and nervous disorders, sanitorium and other institutional care, conditions covered by workmens' compensation law, and those resulting from service in the armed forces. Hospital bills will be included in the total premium under a contract to be negotiated with the Associated Hospital Service of New York.

The proposals of HIP to experiment with group practice, together with the increasing interest shown in this method of practice amongst medical men in the East (where little has been done with group practice as contrasted to the Middle and Far West) plus the expressed interest of many medical officers in the armed forces in group practice, have stimulated the local medical societies through their Coordinating Council to study group practice plans.

It is expected that a statement or formula for approval of group practice will be passed upon by the Coordinating Council in the early fall and recommended to the constituent county societies represented in the Council. Thereafter it may be expected that active experimentation in the provision of the medical care through group units will get under way rapidly in New York City.

Dr. Clark comes to the Health Insurance Plan of Greater New York after a varied and extensive experience in medical administrative work. He was born in Minnesota forty years ago; graduated from Princeton; went to Oxford as a Rhodes scholar and trained in medicine at Johns Hopkins where he graduated in 1932. He held several psychiatric residencies and became a fellow of the National Research Council where he was credited with important research work in the effects of nerve impulses on muscle fibers. Later he made a survey on medical care in the Appalachian coal fields and joined the United States Public Health Service in 1939. He has conducted surveys of health and medical care during wartime in various war-boom areas. He served as Chief of the hospital section in the Office of Civilian Defense and became Chief Medical Officer of the Federal Vocational Rehabilitation Division in 1943-44. He is at present a commissioned officer of the USPHS, assistant director of its public health methods division with the rank of Senior Surgeon, on leave to the HIP.

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## Prepaid Medical Service Plans in Other States

### OHIO

Articles for incorporation of the "Ohio Medical Indemnity, Inc." have been filed with the Secretary of State by the officials of the Ohio State Medical Association. The new company expects to be ready to enroll subscribers before August 1, according to Dr. L. H. Schriver of Cincinnati, president of the Ohio State Medical Association.

### INDIANA AND ILLINOIS

Illinois and Indiana Health Insurance Committees will be ready to submit reports and recommendations to their respective House of Delegates when ODT authority is obtained for the delegates to meet. Dr. Charles H. Phifer, chairman of the Illinois Committee reports, "This Committee has been currently engaged in making a special study of all prepayment plans for medical, surgical and hospital care in the United States. The Committee has interviewed representatives of industrial organizations, railroads, insurance carriers, agricultural organizations, charitable hospitals and institutions in the State of Illinois. They likewise interviewed the medical



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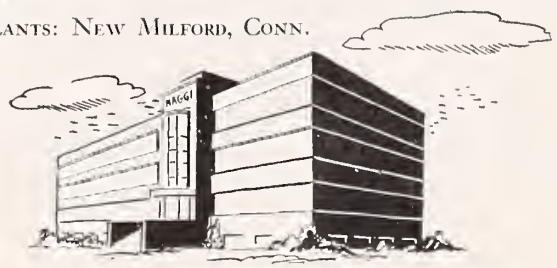



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representatives of the neighboring states regarding prepayment plans for medical, surgical and hospital care that are operating in their states or are in the process of formation."

In Indiana the Committee, headed by Dr. W. U. Kennedy of New Castle, has been divided into three subcommittees each studying separate phases of the insurance problem. These subcommittees are ready to make their reports to the parent committee which in turn will report to the House of Delegates.

# NEWS
## *from County Associations*

### New London

Clarence G. Thompson of Norwich has been appointed health officer of the town of Preston.

John C. Leonard, associate director of the Joseph H. Pratt Diagnostic Hospital, Boston, addressed the Wartime Graduate Medical Meeting held at the U. S. Naval Submarine Base, New London, on August 23. His subject was "The Therapeutic Use of the Sulfa Drugs and Penicillin." Dinner was served following the meeting.

The W. W. Backus Hospital, Norwich, acquired two new interns on July 1, viz., Joseph M. Ganey, Boston University School of Medicine, and George D. Rousseau, University of Vermont School of Medicine.

Dr. Riley H. Guthrie, superintendent of the Norwich State Hospital, has announced the appointment, with the approval of the Board of Trustees, of a visiting staff and a consulting staff who are willing to serve the hospital. He emphasized the shortage of full time professional personnel during the war emergency, and expressed the hope that the close association between physical diseases and psychiatric disorders would be better understood and more competently treated by obtaining the assistance and encouraging the interest of medical men in the community in the various specialties.

The members of the visiting staff are: Robert R. Agnew, surgery; Harold Bergendahl, surgery; Lewis Sears, internal medicine; Casimir Bielecki, anesthesia; Clarence G. Thompson, internal medicine; and Kenneth Kinney, roentgenology (Willimantic).

The members of the consulting staff are: George H. Gildersleeve, urology; John W. Callahan, surgery; David Sussler, surgery; William Victor Wener, surgery; R. Glenn Urquahart, thoracic surgery; Harold Wellington, orthopedic surgery (New London); Alfred Labensky, internal medicine (New London); William H. Weidman, pulmonary diseases; Harold W. Higgins, gynecology and obstetrics; Kopland K. Markoff, ophthalmology; Joseph J. Mahoney, otolaryngology; Edward J. Kirby, dentistry.

### Tolland

Neil A. Dayton, superintendent of Mansfield State Training School, has transferred his membership to Windham County Medical Association because of professional associations.

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### Deaths of Infants from Smothering

Public health education to prevent deaths of infants from smothering, the leading cause of death from accidents in the first year of life, is urged by Dr. Harold Abramson in a report of a study of infants who died from this cause, published in the November 1944 *Journal of Pediatrics*. The study included 139 infants less than one year of age who died in New York City during the five year period January 1939 to December 1943 from accidental mechanical suffocation.

Most of the deaths took place during November, December and January, and as far as could be learned between 6:00 A. M. and 9 A. M. Eighty-six of the infants were found dead with their faces downward. Nineteen infants were found smothered in the mother's bed where they had been taken for an early morning feeding.

To prevent this catastrophe, Dr. Abramson's recommendations concern use of clothing and bedclothing that leave the baby free to move unhampered, avoidance of pillows, use of a flat mattress, careful arrangement of bedclothes to prevent loosening of pads, rubber sheets, and undersheets, and elimination of unnecessary articles such as decorative pillows and odd unattached blankets. The practice of placing an infant face down should be avoided, except during such times as he is carefully attended, and always at night. The infant should never be placed in the mother's bed otherwise unattended. Not only should the infant be carefully attended while being fed but for a period afterward, as many suffocate soon after feeding.

## Saunders Acquires New Art Editor

Willard C. Shepard, of Chicago, one of the foremost contemporary American medical artists has been appointed Art Editor of W. B. Saunders Company, Philadelphia and London, publishers to the medical, dental, nursing and allied professions.

Mr. Shepard studied under the great pioneer medical artist, the late Professor Max Brodel of Johns Hopkins University Medical School, Baltimore, and is widely known by the medical profession for his life-like illustrations of many medical books and medical journal articles. He is a native of New York State, attended Oregon State College and received his art education at the McLeod School of Art, Los Angeles, the Art Institute of Chicago and the Brodel School at Johns Hopkins University. Since 1916, he has been medical artist to the Rush Medical College and the Presbyterian Hospital, Chicago, and, for the past several years, a general faculty member of the Department of Illustration of the University of Illinois College of Medicine.

Mr. Shepard will have his studio in the main offices of W. B. Saunders Company on West Washington Square, Philadelphia, and will concentrate his talents on the more effective utilization of medical illustration to the benefit of medical education and clinical practice.

The latest contribution of this distinguished illustrator is a Manual of Surgical Anatomy in which he collaborates with Tom Jones, Professor of Medical and Dental Illustration at the University of Illinois. This Manual will be published by W. B. Saunders Company under the auspices of the National Research Council and will be specially designed for use of medical officers of the Armed Forces.

## New Journal of Parenteral Therapy Published

Publication of a new quarterly, *The Journal of Parenteral Therapy*, is announced by Science Publications Council, New York. Among the topics discussed in the first issue, dated Fall, 1944, are parenteral dosages of penicillin, human serum albumin concentrated, sterile medicaments, painless venipuncture, intravenous therapy and literature on shock. Other subjects listed with which the new journal will treat, include: amino acids, blood transfusion, body fluids, chemotherapy, dextrose and glucose solutions, nutrition, plasma, postoperative care, pyrogens, serums, trauma and war medicine.


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"Dramatic progress in medicine since the outbreak of World War II underlies the need for *The Journal of Parenteral Therapy*," it is stated in the opening editorial. Despite the great importance which parenteral therapy is rapidly assuming in medical practice, no journal or section of a journal hitherto has dealt exclusively with this subject, the editorial points out. "Instruction in the techniques of parenteral therapy has been haphazard and unorganized," it is stated.

The advisory editorial board of *The Journal of Parenteral Therapy* includes the following physicians and surgeons: W. Wayne Babcock, Philadelphia; I. A. Bigger, Richmond, Va.; Alexander W. Blain, Detroit; Frederick A. Coller, Ann Arbor, Mich.; Joseph H. Fobes, New York; Henry N. Harkins, Baltimore; Lester Hollander, Pittsburgh; Alton Ochsner, New Orleans; Max M. Strumia, Bryn Mawr, Pa.; George J. Thomas, Pittsburgh; Justus J. Schifferes, New York, is managing editor.

Distribution of the new publication to 16,000 surgeons and hospital executives, to all internes and medical libraries is made possible by a grant from Hospital Liquids, Inc., Chicago.

## During Food Shortages

It is well to bear in mind that *dried brewers yeast, weight for weight, is the richest food source of the Vitamin B Complex.* For example, as little as 1 level teaspoonful (2.5 Gm.) Mead's Brewers Yeast Powder supplies: 45% of the average adult daily thiamine allowing, 8% of the average adult daily riboflavin allowance, 10% of the average adult daily niacin allowance.

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## The 1945 Soviet Budget

The 1945 budget of 307.9 billion rubles allocates 66.1 billion rubles, or 22 per cent of the total expenditures, for education, health, social and cultural services. There will be an increase of 2,800,000 pupils in primary and secondary schools this year as compared with 1944. The number of students of universities and higher technical schools will increase by nearly one-third and will approximate the prewar figure.

A 50 per cent increase as compared with last year is provided for the financing of scientific institutions, which is indicative of the attention science receives in the U. S. S. R.

Large appropriations are provided for child welfare institutions. The welfare of mother and child is given great attention by the Soviet State. The number of mothers receiving grants from the Government increased by nearly 50 per cent in the second half of 1944. Grants to mothers of large families and unmarried mothers in 1945 will be 500 million rubles more than in 1944.

Care of disabled soldiers is one of the prime concerns of the Soviet Government and the public. Under the Constitution every citizen has the right to social maintenance in sickness, old age or loss of working capacity. This provision of the fundamental law finds practical expression in the 1945 budget which allocates 18 billion rubles; or two billion rubles more than in 1944, for social maintenance, including pensions and grants to soldiers and their families.

## From The Doctor's Own Wife—His Fourth Investment

J. B. McCLINTON, M.B., B.SC.MED.
in Virginia Medical Monthly

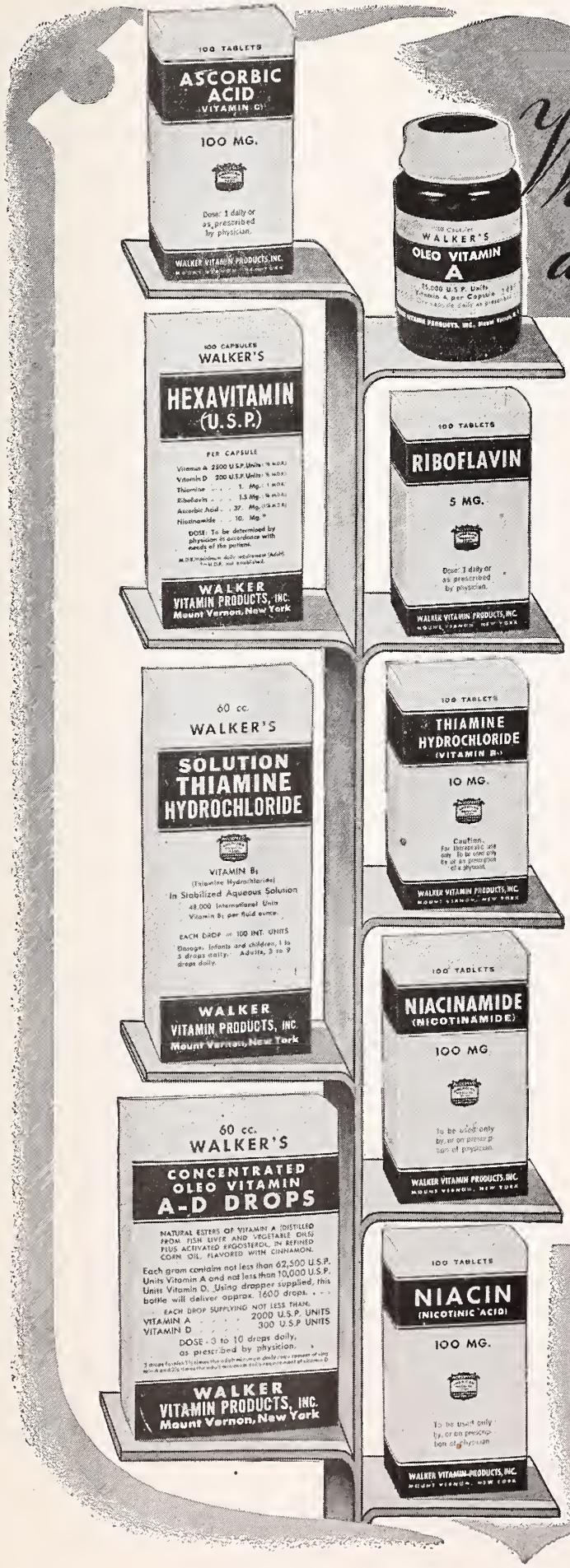
The doctor's children have 50 per cent more chance of being failures than their kind because there is only one to teach them. She must hurry them to the toilet, walk them to Sunday School and wave to them at graduation all alone. The doctor is busy.

* * * *

Of one hundred consecutive patients entering an office only two asked how the doctor was. One, an optimist wanted to borrow a hundred dollars; the other wanted a drink. People are interested in themselves. They cooperate like nations when their skins are in danger.

* * * *

Charm is a tiny grain that's found when the kettle of life boils nearly dry. The doctor's wife should have it. It's like the fragrance of scented cedar between the pages of a long unopened book. It belongs to those who love people, jobs, broken dolls and the architecture of cathedrals. People have it who worry about the loss of an old vase, the bombing of children, or a puppy's swollen ear. Like old mahogany




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## Formula Shows Promise As An Effective Fungicide

The Connecticut Association for the Advancement of Professional Pharmacy reports that although many chemicals have been tried for the treatment of "Athlete's foot," few mercuriated compounds have been investigated for this purpose, probably due to the danger of mercury poisoning. Since mercuriated derivates of carvacrol have been shown to retain their phenolic character, yet contain a rather high percentage of mercury, Dr. Carl E. Georgi of the University of Nebraska set out to determine what effect monochlormercuricarvacrol would have on pathogenic fungi in vitro.

Epidermophyton, Trichophyton, Monilia and Staphylococcus aureus were included in the tests; the particular species used were considered representative of those encountered in fungous infections of the skin. Observations were made on the penetration of various preparations through an agar substrate simulating body tissue, and their activity was also observed in the presence of blood serum.

The four principal preparations tested were (1) monochlormercuricarvacrol in a fatty base, (2) Ointment of Benzoic and Salicylic Acid, N.F., (3) salicylic acid, benzoic acid and thymol in a hydrophilic base and (4) monochlormercuricarvacrol, salicylic acid and benzoic acid in a hydrophilic base.

By far the most effective, based on the zones of inhibition reported (Arch. Derm. Syph., 48:497, 1943) was the last formula which can be prepared as follows:

| | |
|---|---|
| Monochlormercuricarvacrol | 1.5 |
| Salcylic Acid | 3.0 |
| Benzoic Acid | 6.0 |
| Soluble base, q.s. ad | 100.0 |

RECOMMENDED BASE

| | |
|---|---|
| Glycerin monosterate | 10. |
| Glycerin | 20. |
| Bentonite | 2. |
| Water | 68. |

Reference: *Journal of the American Pharmaceutical Association*, Practical Pharmacy Edition, Vol. V, Nos. 6 and 7, June-July, 1944, page 183.

# NEW BOOKS IN REVIEW

*MEDICINE AND THE NEUROSES: Report of the Hershey Conference on Psychiatric Rehabilitation. National Committee for Mental Hygiene, Inc., N. Y.* 1945. 36 pp.

Reviewed by C. C. Burlingame

Early this year, a group of military and civilian psychiatrists, internists and medical educators met at Hershey, Pennsylvania, under the aegis of the National Committee for Mental Hygiene and the Commonwealth Fund to discuss the urgent problems connected with war neursoes and ways of mobilizing and increasing the medical resources available for their handling. In a stimulating and provocative report appropriately entitled "Medicine and the Neuroses" the reflections and recommendations of the Conference have been recently set forth.

At first glance the report seems to place undue emphasis on the size of the psychiatric problem precipitated by the war, but more careful perusal shows that the statistics have been judiciously qualified, and it is possible to concur with the general conclusion that the need for professional help in overcoming psychiatric handicaps can only be met by an expansion and reorientation of psychiatric services, both in specialized and general directions.

The Conference has made a number of constructive suggestions with regard to emphases in medical education and comprehensive medical care, together with recommendations relating to the development of facilities for the treatment of psychoneurotic reactions and the very important task of public education.

All physicians should read this timely brochure and ponder it well.

*THE MANAGEMENT OF OBSTETRIC DIFFICULTIES.* (Third Edition.) *By Paul Titus,* M.D., Obstetrician and Gynecologist to the St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to the Homestead Hospital, Homestead, Pa.; Secretary of the American Board of Obstetrics and Gynecology; Commander (MC)USNR, attached to the Professional Division, Bureau of Medicine and Surgery, Navy Department, Washington, D. C. *St. Louis:* C. V. Mosby Company. 1945. 1,000 pp. with 426 illustrations and 8 color plates. $10.00.

Reviewed by Stanley B. Weld

This continues to be one of the best references in the field of obstetrics. It is eight years since the second edition of this text was published and in this period many changes have transpired affecting the practice of obstetrics. The problem of sterility has received more intensive study, especially the male factor. This is reflected in the author's chapter on this subject. New classifications of the toxemias are included and the treatment brought up to date, utilizing the vitamins in the first trimester.

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Salinger, S.: Arch. Otolaryng. 4:40, 324,
noting Box, H.E.H.: M. J. Australia 2:126.

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*Literature and Sample on Request*

In the chapter on the contracted pelvis the results of Dr. Thoms' pioneer work are more in evidence than in previous editions. The technic of x-ray pelvimetry and cephalometry covers the methods of Thoms and of Caldwell and Moloy and is a welcome addition to this edition. The omission of avertin analgesia and the addition of several pages on caudal analgesia brings the management of this phase of labor more nearly up to date. As the author states, the entire subject of obstetric analgesia is still in a state of flux and one cannot pretend in a text book such as this to keep abreast of the variations in development. This accounts for the omission of one of the most recent analgesics, demerol.

The chapter on intravenous infusion and blood transfusions has been completely revised. A discussion of the Rh factor and erythroblastosis brings this subject up to date at the time of publication. Much work is yet to be done on this intricate problem so that any text will require frequent revision but the discussion in Dr. Titus's book is an excellent one in condensed form.

This edition, though published in war time, contains over 100 more illustrations and twice as many color plates as are found in the previous edition. The binding and paper are better than the average.

*PUBLIC MEDICAL CARE PRINCIPLES AND PROBLEMS. By Franz Goldman*, M.D., Associate Clinical Professor of Public Health, Yale University School of Medicine; Lecturer, New York School of Social Work. *New York: Columbia University Press.* 1945. 226 pp. $2.75.

Reviewed by STANLEY B. WELD

This book is said to be the first attempt ever made to give a composite picture of public medical care as a social movement. It is organized in two parts. In the first part the author attempts to analyze, interpret, and appraise public policy in providing, at public expense, facilities and services for the care of the sick. He calls attention to the fact that the principle of specialized service in the care of the sick has not

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been carried far enough in that chronic disease and convalescent hospitals have been "sadly neglected." Hospitalization for communicable disease ought to be more readily available to the common man. Attention is called, and quite correctly, to the uneven distribution of hospital beds, both general and special. He decries the dependence of the physician for his livelihood on fees from patients. He points out the issue before the profession and the public at the present time of whether medical practice should and can be organized on the basis of medical centers or whether such approach would be contrary to the best interests of all concerned. Public general hospitals receive the author's condemnation as failing to provide all necessary special facilities. Professional supervision of professional matters is held up as a feature of the newer policy of medical care.

The second part of the volume is concerned with planning for medical care by planning for (1) medical care facilities serving the community; (2) organized professional services; (3) methods of payment for both the establishment of necessary facilities and the services rendered by institutions and health professions; and (4) administrative procedures to assure early diagnosis, early, prompt, and thorough treatment, high standards of service, and continuity and consistency of care. Separate facilities for convalescent care are advocated. Medical centers are believed necessary. Nationwide licenses instead of state licenses are a necessity.

The author is an advocate of compulsory health insurance as the only solution "because it alone is applicable to marginal income groups as well as others." And compulsory health insurance means taxation. To accomplish the optimum administration Dr. Goldman would set up centralization of certain powers (i.e., in the Federal Government) and decentralization of certain functions. Training of specialists in medical care administration would be a necessity. His philosophy underlying modern health policy is expressed in one of the closing paragraphs where he states such a philosophy rests on two cornerstones: society's need of the fit and productive individual and the individual's right to health.

Dr. Goldman is an advocate of the Wagner-Murray-Dingell Bill. His book presents a strong argument for its proponents but it does not prove that medical care would be improved by placing it in the hands of medical bureaucracies.

*COMMON AILMENTS OF MAN. Edited by Morris Fishbein*, M.D., Editor, *Journal of the American Medical Association*, and *Hygeia*, the Health Magazine. *New York: Garden City Publishing Co., Inc.* 1945. 177 pp. $1.00.

Reviewed by STANLEY B. WELD

This volume comprises a discussion of sixteen conditions, each by an expert in that field. Many of the conditions are symptoms rather than diseases. Each article has appeared in *Hygeia* and was written for the laity. All have been revised and brought up to date. It is an excellent volume to place on the physician's waiting room table or in the hands of his patients.




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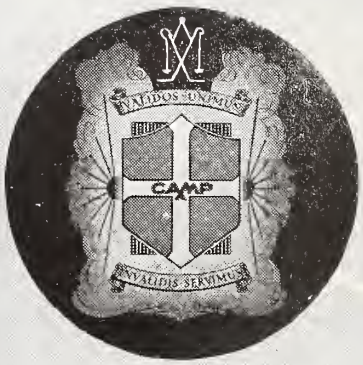
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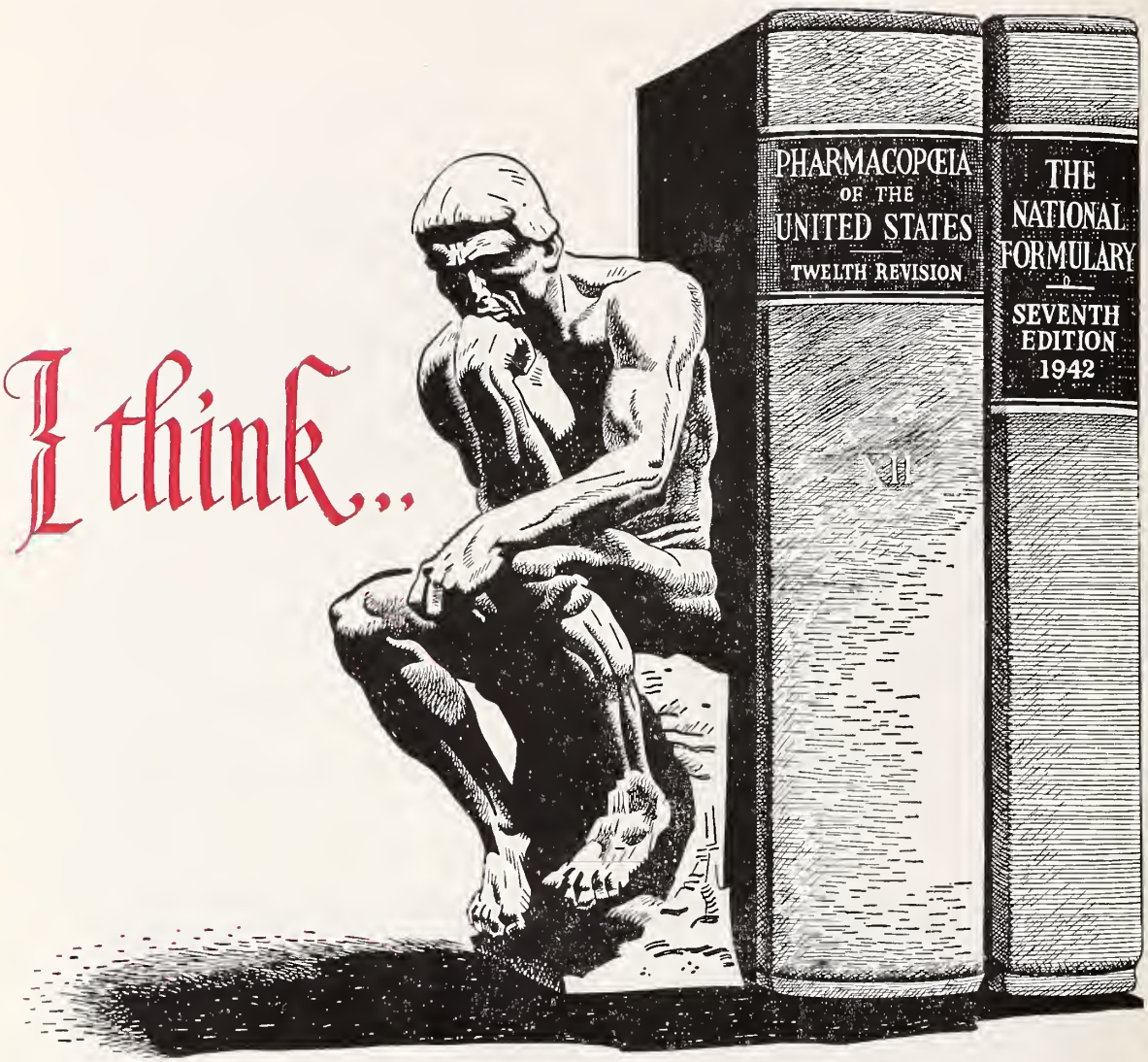
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The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. IX NOVEMBER, 1945 No. 11

# ADDRESS OF MAJOR GENERAL PAUL R. HAWLEY, MC—USA

Thank you very much, my friends. I am fully aware of the inconvenience to which you put yourselves by waiting so long for me to get here. I apologize. I assure you that it was because of another engagement in Washington at noon, which I simply could not get excused from. I should like to make one correction; I noticed it on your program, and it is, of course, quite a natural correction. I am not the Medical Director of the Veterans Administration, but merely an advisor of the administrator, loaned to him from the War Department, to help him with the problems which confront him.

I should like to speak to you on the medical problems which confront the Veterans Administration. I think that is a fitter subject for a five foot shelf of books than for a thirty minute talk, and yet I shall boil them down into two main heads. So deeply do I feel these problems, and so much do I want the professional of the country to realize these problems, that I have not prepared a set talk for you, and it perhaps will not be smooth oratory. I hope what it does lack in oratory will be made up in sincerity.

The problems that confront the Medical Service of the Veterans Administration are two, personnel and beds. All problems fall under one of those two headings. First let us discuss the beds which are something that we can buy eventually, and dismiss those problems in a very few words. There is a great deficit in beds right now. There are more than ten thousand more patients in Veterans Administration Hospitals right now than there are beds for them, and those are all in general medical and surgical hospitals and in neuropsychiatric hospitals because the Veterans Administration has refused to overcrowd hospitals for tuberculosis patients. That does not tell the story. Before we can get any more beds built there is going to be a deficit of forty thousands beds. By June, 1947, by the thirtieth of June, we estimate that we will be forty thousand beds short to take care of the load which will fall on these hospitals. Now, this present overcrowding of ten thousand patients is a very serious thing. It means that sun porches and recreational rooms, which are an essential part of the treatment, certainly, of long duration patients, have all been taken up and crowded with beds. Three-bed wards now have four beds in them. The kitchen facilities for cooking for nine hundred patients in one hospital, for example, are now cooking for twenty-seven hundred patients without any expansion, and with a perfectly obvious deterioration in service. Water supplies were overtaxed by overcrowding of hospitals, particularly in the neuropsychiatric hospitals, where the overcrowding is greater than in any other type of hospital. Now, nothing that I say here must be taken as being critical of the Administration, of the Veterans Administration, for the past years. There are perfectly good reasons why things were done. I think I can say, without being critical, that the planning of the Medical Service was not always in the interest of the best medical care. The beds were located almost exclusively, let us say, by the geographical distribution of the veteran population. Now, that has its merits. I might say that those locations were very occasionally to get hospitals in certain Congressional Districts, but in the main, the only policy followed in the location of the Veterans Administration Hospitals was to get them somewhere near the center of veteran population for that particular area of the United States. This would be a perfectly defensible policy even by medical people if it were

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

always going to be possible to staff all of these hospitals with thoroughly qualified, full time men in the specialties that modern medicine demands for good medical care. When you build hospitals in outlying places, away from the assistance of all medical centers, you are forced to provide full staffs, and this policy which has been followed in the past, now acutely emphasizes and increases our next problem which is that of the shortage of medical personnel.

We are now short some thirteen hundred doctors to take care of the patients we have, and some six hundred dentists. We have an even greater shortage, a shortage which is much more serious than a shortage of numbers. We have a shortage of trained specialists. Many of the specialists trained in the Veterans Administration in past years have gone into the Armed Services. Most of those will come back eventually, but the Veterans Administration has had to call upon the Army and Navy for doctors to help them in this emergency, and in general, there are many exceptions to this rule, but in general those doctors have been furnished without much regard for the specialties that were required. We find in all of our large hospitals, and I speak completely, innocently of the situation at this hospital, because I have never seen it before and I don't know, but the hospitals that I have visited there is not only anywhere from a twenty-five per cent to a forty per cent shortage of doctors, but some of the specialties, the essential specialties, are simply not represented at all. Now, you as medical people will understand the seriousness of this situation, and how this cannot be corrected in a week or in a month or in a year. I can tell you that it is going to take a long time to correct this situation which has grown up over a number of years. That does not mean for one minute that we are discouraged about it, although we are appalled at the magnitude of the problem which we found facing us. But it is going to take an awful lot of doing to correct these evils. Now, what kind of doings is it is going to take? Well, first we have got to provide for the full time personnel in the Veterans Administration a better sort of career than has been offered to them before. We have got to insist on only good men in full time service in the Veterans Administration, and you cannot get full time men, and keep them enthusiastic, without offering them some kind of career. There is a bill already in Congress to provide that. That bill has many faults which are being ironed out, and I have no doubt will be pased within the next few weeks. I might say that because it has the approval of the Administrator that that one addition that we made to that bill was to provide a flat twenty-five per cent increase in pay in every grade for a Medical Officer who qualifies as a specialist by becoming a Diplomate of a recognized American Specialty Board, and by approval of the Medical Director of the Veterans Administration, and is some incentive for the young men to qualify. I think all of us in this room are perfectly willing to risk our professional reputations upon a group of medical men who are Diplomates of the American Board, but we can't ask young men to work their heart out getting this coveted distinction without giving them some recognition in the matter of pay. But even if we make it the most attractive public service in the world, we are never going to get enough doctors full time to take care of the veterans. Now you can just start right there. There has been the one great fault and fallacy of all this planning, the idea that you could always get enough doctors to look after the veterans. Though the medical schools of this country are turning out each year less than six thousand, only between five and six thousand graduates, the average expectancy of a doctor in active practice I don't want to get tangled up with my friends down here not life expectancy, but expectancy in practice is about twenty years. That means that graduates of medical schools, only to the number, we'll say five hundred, and it hasn't been going up, can only support a medical population in this country of a hundred and ten thousand doctors. We have one hundred and forty thousand doctors in active practice in this country today, which means that the medical population of this country is going to decrease constantly while the population of the country increases. Furthermore, there haven't been any young men started into premedical work except for the few that are not physically qualified for the Army or Navy in how long, two years, isn't it? I don't know, I have been away for four years. And so, come eight or nine years from now, we are going to have some very lean years, and not by any means are five thousand going to be graduated. The committments of the Army and Navy for occupational forces will require an unusually large number of doctors every year, and I know from my thirty years in the Army how difficult it has been to get even enough doctors to keep a corps of twelve hundred and eighty officers going, doctors of the right kind. It is awfully difficult to get them, and here we will require, within five years perhaps, we would require as many as five thousand, four or five thousand, to get full time

medical service for the veterans, over and above what is required by the Army and the Navy and the Public Health Service and the full time physicians in the state and city governments. It does not require any gigantic intellect to convince yourselves that it is going to be completely impossible to take care of the veteran without a full time medical service. So, we have got to have a full time medical service for many reasons.

We have got to have a continuity in service in every hospital and then we fallen heir to ninety-five hospitals, about ninety of which are built inaccessible to any large groups of medical people on the outside that we can expect part time help from, and we have got to staff those. I am only talking now about hospital care, and there is another big thing we have not touched. How are we going to do this in the future? Well, first we have got to offer professional opportunities to these full time men in the Veterans Administration Medical Service. We have got to offer them opportunities as youngsters to qualify before an American Board, and we have got to offer them repeated opportunities during their career to come in contact again with medicine, with teaching medicine. We have got to offer them something in lieu of the money they would make if they engaged in private practice, and so we have got to offer them professional interest and professional stimulation for their own good as well as, of course, for the good of the patient. We have got to have an awful lot of help from the civil profession, part time help. The Government will never pay civilian doctors as much as they can make in private practice. They won't pay them as much part time as they could get, perhaps, during that time they spent on Government business. But, this is a public duty, the care of the veteran, to which every citizen of the United States is committed, and each must contribute in the way that he can best contribute. Furthermore, I feel very strongly and I want to make this very clear, this is not in the nature of a threat, I am talking as one doctor here to other doctors, I feel that if the organized medical profession of America lets this program fail for want of their own support, that they have taken just another step toward State medicine which is not very popular in the civil profession. I feel that by recognizing this responsibility, this opportunity to serve, to contribute voluntarily to this program which is very close to the heart of the people, that they will re-establish, not that they have lost it, but in the hearts and the estimation of the people, a position which is going to be very hard to attack. We shall have State medicine and social medicine in this country only when the people feel that the profession, as a profession, has failed to give the people the service that the people want.

How more are we going to improve these hospitals? The very best hospitals in America are, let us say, I want to say that a little different—let us say that there are no bad teaching hospitals in America, there are other hospitals that are not teaching hospitals that are good hospitals, but there are no teaching hospitals in this country that are bad hospitals. The best way that I know to keep the staff on their toes, to provide professional stimulation for the staff of that hospital, to have a keen bunch of young residents in there, for three or four years until they qualify for their Board and they must be tops, and there must be a teaching program if you are going to get residents, because no hospital will be approved for residencies unless that teaching program is in effect in that hospital. So, I should like to see residencies established in every Veterans Hospital. That is going to be impossible because there are other factors to prevent every one to be recognized for residency. Already seven have been approved for surgical residencies. I haven't been able to find out yet why the residents have not been appointed, but the American College of Surgeons is very, very anxious to get those surgical residents in these seven Veterans Administration hospitals which have been approved. My psychiatrist friends tell me that there is a very great shortage of psychiatrists in this country. There are only thirty-six hundred registered psychiatrists, and they feel that some of those are not awfully well trained. There is a very great need for training psychiatrists in this country, and that there are very few facilities now provided outside the Veterans Administration for the training of psychiatrists, certainly not in the numbers needed. I should like very much to see, and now taking down notes be sure that you say I should like very much to see instead of that I am going to do which is quite a different thing, I should very much like to see at least four psychiatric institutes established within the Veterans Administration where their own people can be trained in psychiatry and which would be opened without any undue bonds upon young doctors not connected with the Administration to come there and study also. I think it would make a contribution to American medicine as well as to elevate the standard of care of our psychotics. Now, these are not dreams. They are to me very real ideas, but

I want to tell you where the fences are on which these horses will fall.

There has grown up, and it has been fostered, I think somewhat for political reasons, it has been fostered by some of the Veterans Administration, that it is a terrible thing to take the patient very far away from his home. Well, you cannot provide specialized medicine and keep every patient within a stone's throw of their home. You have got to take your patients where your doctors are, and you are never going to have enough specialists to scatter them around in every Veterans Administration hospital in this country and provide a top-notch medical service. With sixteen thousand doctors in the European Theatre we never had enough specialists of a certain type to put them in every hospital. We had to train a lot, and one of the great jobs of training, I say at the risk of embarrassing him, was done by Col. Tovell in training anesthetists, because the hospitals that came to us never had enough anesthetists, and very few of them had trained anesthetists. It was only by training those anesthetists to a high standard that we were able to do the marvelous chest surgery that was done in that theatre. It all ties in, one after another—if you haven't got good anesthetists you cannot do chest surgery, and if you haven't got chest surgeons you cannot do it, but you have to have both. We have got to educate the people of the country that it is much better to take their boy a little farther from home and give him good medical care than to keep him at home and give him bad medical care. The curious thing is that the most objection to that comes from the long-duration patient, and the longest duration of all patients are the psychotic patients. We have no objection when we start to move a psychotic patient from one hospital to another on the part of families when the facts show that after the first three or four months in a psychotic hospital ninety-five per cent of the families stop visiting the patient anyway. It is a matter of sentiment more or less with them, and it has been encouraged, I think, perhaps for political reasons. We must all, and nobody can educate a family like a family physician, and so you people that are practicing medicine with these families are in contact, must break down that prejudice, and it is just a prejudice. It has ruined our psychiatric hospitals because they are filled up with chronic domiciliary cases that just need a little bit of looking after and a little bit of guidance, I shall not say restraint, I mean restraint only in the sense in the cases that should not be wandering around in the community but they are quite docile, and all they need is a chance to do something, to work with tools or to work on the land, and they are going to be wards of the Government from now on. There is nothing we can do for them in the present state of medicine. We should have acute psychotic hospitals, particularly for these acute cases of the World War II veterans because you cannot mix these old chronic cases which are just to be cared for but not treated with the acute case that needs a lot of treatment and run a good hospital. The minute we try to classify hospitals and move to a large farm of five hundred acres these chronic cases you get "howls" coming from everybody and it is stopped. Those are the obstacles that are placed in the way of doing what I think is good medicine. I may be wrong as to what constitutes good medicine, but in defense of my judgment I shall say I have seen the best medicine that has ever been practiced in the European Theatre of Operations, and I think that any doctor that has been over there will not dispute that.

There is one other most important thing that we are confronted with, and that is the out-patient care of the veterans. That obviously has got to be done by the civil profession. There are many inconveniences associated with that at the moment, and whether they will be corrected I would not know. One is that the World War II veteran is entitled to out-patient service only for service-connected disabilities, and upon that law is written a regulation that he must first obtain the authority of the Regional Manager of the Veterans Administration before he can consult a doctor and have the disability cared for. Of course, if he is a hundred miles from a Regional Manager that requires some time to secure that. It seemed to me rather paradoxical to find in the schedule of fees, fees for calls in the middle of the night for service-connected disability when first he must call a hundred to a hundred and fifty miles and get a Regional Manager out of bed whose home telephone number he does not know, in order to get permission to call a doctor. Those are things which, of course, will be straightened out. Whether they will be straightened out by doing in the case of the World War II veteran what is practically done in the case of the World War I veteran, consider everything as service connected, I do not know. But the fact is that this out-patient care has got to be given by the civil practitioner. Now what happens when we try to build up a fine out-patient service. I am not blaming you and I

know what you had to go through in the best, we try to get a good doctor to take it, and he will not take it. Not always, but many times, the busy man will not bother with it. We have got to depend on local medical societies to recommend the high type men for appointment to these positions. It may be Congress will pass a law something like a Health Insurance Law to permit the veteran to choose his own physician, and I have no argument against that at all, something like a group health insurance plan that any physician that agrees to serve the veteran can choose. That will save the Veterans Administration an awful lot of headaches, but at the moment we are faced with the fact that the Veterans Administration must approve the physicians who are appointed to do the out-patient work, and there is no rule or regulation which prevents the appointment of two, three, four, or five in every community. But when, as we shall soon, write to the local medical society for recommendations, I ask you very seriously to consider that public duty, and not out of the feeling that here is a poor chap that is scarcely making a living anyhow and let's give it to him, let us have the local societies act in a critical way in the best interests of the veteran and recommend only men who will give the veteran the type of medical care to which he is entitled.

It has been a great privilege for me to come up here this afternoon. I should like to see this kind of meeting in every Veterans Hospital in the United States. The Veterans Administration is deeply indebted to you men of the Connecticut State Medical Society for giving your time, showing your interest, and for coming here. I hope that this idea catches on and spreads as rapidly as possible all over the United States because, after all, these are your boys. They are the boys of the families that you treat, and this is your problem and no Government bureau in the world can solve it alone without your help. Thank you very much.

# MEDICAL CARE OF THE NAVAL VETERAN

Captain Howard H. Montgomery, MC—USN

A review of the types of medical care which is given personnel of the Navy, Marine Corps, and Coast Guard before discharge for medical reasons and consideration of the causes for such separations may give some indication of the medical care they may require from physicians in private practice and from facilities of the Veterans Administration after return to their homes.

The Navy's plan for the care of all casualties, whether due to combat, to the hazards of duty at sea and on foreign shores, or to the normal hazards of everyday life, is based on the following general principles:

First: Immediate medical attention, which includes measures for the control of shock, hemorrhage, and infection even in the midst of battle.

Second: Prompt evacuation from combat areas to hospitals in rear areas, or in the more severe cases, to hospitals in the United States.

Third: Continuity of medical care, carrying out an integrated and unbroken chain of treatment from the battlefield, through air or sea evacuation, to the place of definitive treatment.

Fourth: Utilization of all accepted therapeutic measures and aids developed by civilian and military research, and their application to field conditions.

Fifth: Establishment of specialized centers in our general hospitlas to care for specific diseases and injuries; and

Sixth: Employment of the auxiliary services of the Rehabilitation Program to supplement the usual methods of clinical treatment.

The success of this program is shown in the fact that out of every hundred casualties who have lived until medical treatment could be administered, 97 have survived, the great majority of them to return to active duty. This record has been due in part to the availability of such therapeutic aids as the sulfa

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society*

*The views and opinions expressed herein are those of the author and are not necessarily those of the Navy Department*

drugs, penicillin, plasma, and whole blood for use immediately after injury. The rapidity with which patients have been evacuated to hospitals has also been a contributing factor. Field hospitals were often set up very close behind the front lines, hospital ships operated with the invasion fleets, and air evacuation brought thousands of casualties to hospitals in rear areas within a few hours of being hurt.

Once survival was assured, the problem became one of rapidly restoring the patient to condition to resume his duties, or, if that was impossible, to prepare him as thoroughly as possible for return to civil life as a well adjusted, capable, and independent member of society. The latter bears on the matters we are considering today.

Although the hospitals of the Navy are general hospitals in the sense that they receive all types of cases it was found expedient to designate certain of them as centers for treatment of conditions which require highly specialized medical staffs or special services.

Four centers for neurosurgery and plastic surgery are in operation, two for tuberculosis, two for rheumatic fever in its acute stages, and one for convalescents from this disease, and others for anterior poliomyelitis, malignant tumors and psychoses.

Time does not permit discussion of the work being done in these centers. Suffice it to say that some remarkable results are being obtained. I do want to bring to your attention, however, some of the work of the centers for the blinded and deafened at the U. S. Naval Hospital, Philadelphia, for the amputees at U. S. Naval Hospitals, Philadelphia and Mare Island, California, and for patients with transverse myelitis at U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, California.

The blind, defined in the Navy as those having a visual acuity of 20/200 or less in the better eye, are transferred to Philadelphia as soon as their physical condition will permit. On arrival, they are examined to determine the course of medical and surgical treatment required, which, incidentally, has restored better than 20/200 vision to about 15 per cent of the patients. Information is obtained as to their education, vocational experience and desires, family and social situation, and any other data of value in laying out an individualized program of rehabilitation.

First in importance, as well as in time, is a course of general orientation and training in the fundamental techniques of daily life, such as eating, dressing, and getting about unaided. The realization of ability to perform these simple but essential tasks is the first great step in restoring the self-confidence of patients and motivating them for the difficult job ahead. Then follows training in Braille, typing, and script writing, which in turn serves as a basis for the educational or vocational courses selected by the patients in consultation with the staff. Occupational therapy builds confidence in their ability to work with their hands, and their self assurance is increased by social activities, and participation in active sports. Finally, careful vocational and psychological testing, plus actual work trials on the type of job preferred, set them on a realistically chosen course to be followed after discharge. This may involve further education or vocational training, under the Veterans Administration, but they are often able to go directly into satisfactory jobs obtained before leaving the hospital.

All cases of deafness involving a loss of 30 decibels or more in the better ear are also cared for at Philadelphia. In many ways, such as in education, vocational training and counselling, and work experience, this program parallels that for the blind, though the problems are, of course, in general less acute, and the range of vocational opportunity wider. Morale is, nevertheless, a serious problem, because of the unfortunate quirk in popular psychology which often regards deafness in others as source of irritation rather than as deserving of sympathy and cooperation. All patients are encouraged to maintain normal social contacts, in order to overcome self consciousness.

There is little new in the medical and surgical management of these cases. Our dependence rests mainly on the careful fitting of hearing aids and on special training. Accurate audiograms, supplemented by speech reception tests, form the basis for tentative selection of a hearing aid; the final selection, however, is made by the patient after thorough trial. Speech reading, which is conceived of as more inclusive than mere lip reading, involves interpretation of the situation as a whole and careful subjective and objective attention to kinesthetic patterns. Auditory training gives practice in the reconstruction of spoken language from the residual frequencies as supplemented by the hearing aid. By these means, losses as profound as 100 and more decibels have been reached, as against the previously generally accepted limit of 85 decibels.

All patients who have undergone amputation of an extremity, are cared for in the two centers at

Philadelphia and at Mare Island. The guillotine, or open circular method has been the standard amputation under field conditions. Preservation of all viable tissue possible was enjoined along with maintenance of skin traction constantly during evacuation, to prevent retraction. Revision is done at the centers, where the most suitable final amputation can be chosen by surgeons who have had exercisive experience in this work. The various physical medicine procedures are employed to condition the stump, develop its remaining musculature, eliminate or avoid contractures, and to develop the rest of the body to accept a compensatory burden. The artificial limbs are manufactured in the shops in these centers for the individual patient who will use them and they incorporate improvements developed as a result of research in these and other hospitals. The limbs are fitted as soon as the stump has healed, so that the period of stump shrinkage may be employed for training in their use. Refitting and adjustment is done as necessary as shrinkage progresses. Training is continued until the amputee has successfully passed an achievement test, covering a wide variety of representative activities which demonstrate his ability to meet the varied demands of ordinary life.

A striking example of the results which may be achieved is to be found in the care of cord bladder cases, for whom a center has recently been established at U. S. Naval Hospital, Santa Margarita Ranch, Oceanside, California. Normal voluntary function cannot of course be regained unless some nerve pathways remain, but such measures as exploration of the cauda equina for scar tissue, and intensive retraining, do succeed in restoring more or less function to some cases which at first sight appear hopeless. The majority, however, can only learn to compensate indirectly for their disability. Maximum physical development and training in the use of caliper braces and crutches enables many a man to overcome the utter helplessness which would formerly have been his lot. Regular physical exercise pays invaluable dividends in avoiding decalcification of bones and the formation of urinary calcula. A transurethral operation for the removal of hypertrophide tissue from the neck of the bladder gives promise of eliminating one of the most distressing features of this condition—the need for continual catheterization.

In the centers, as well as in all hospitals and, as far as possible, in the units overseas, a rehabilitation program is carried out for the benefit not only of the permanently handicapped but of all patients, whatever their condition.

The underlying philosophy is that of treating the patient as a whole, as distinguished from merely treating his illness or injury. Physical training consistent with his condition avoids the weakness and atrophy commonly associated with prolonged hospitalization. Physical therapy and occupational therapy are used to the maximum for the restoration of lost function. Education, often carrying academic credit, and vocational training, both theoretical and practical, help prevent the usual mental inertia and loss of morale, direct the patient's attention to the future instead of the present, and help to prepare him for his life after he leaves the hospital, whether he returns to duty or to civil life. Those who will leave the service are offered legal and social services, as well as vocational counseling and an explanation of their rights and benefits as veterans.

The goal then is to restore all patients, whether handicapped or not, to an optimum state not only of physical health, but of social and economic preparation for the future. No patient is discharged from the service until he is considered to have received the maximum benefit from hospitalization, except those who require prolonged care and are transferred to a Veterans Administration facility. Since the criterion for discharge from the service is attainment of maximum benefit from a medical standpoint, education and vocational training are, of necessity, limited to the time available while under treatment. It is not the purpose of the Medical Department to assume the functions of the Veterans Administration in this regard, but simply to assist the patient to get whatever head start he can in the time at his disposal. In the case of the specially handicapped, the concept of maximum benefit is held to require rehabilitation to the point where the patient will be able, if he so desires, to carry on without further aid, though he is of course encouraged to avail himself to all further assistance which will be of immediate or ultimate benefit to him.

Let us now refer briefly to the statistics of discharges for physical disability from the Navy, Marine Corps, and Coast Guard, to see what light they may throw on the nature and magnitude of the medical problems of veterans. In the period of January 1942, through July 1945, there were 240,271 men and women so discharged from the Service. From an initial level of about 1,600 per month, this rate has steadily increased so that we are now discharging in

the neighborhood of 15,000 monthly, one half of two thirds of them for service-connected disabilities.

There is a natural tendency, when thinking of medical discharges, to think of them as largely due to combat injuries. We find, however, that current figures, which most accurately reflect the ultimate total, show that less than 5 per cent are the result of injuries, including those received in the course of every day pursuits as well as in combat. We can now make a rough prediction of the total numbers of certain categories of the handicapped to be expected as a result of this war: the blind will probably not number more than 200, the deaf perhaps 3,000, and amputations of an extremity in the neighborhood of 2,200. In relation to the overall numbers, then, it will be seen that these conditions represent but a small fraction of the total.

By and large, the causes for medical discharge from the Service are those conditions which occur also, and with similar frequency, in comparable age groups among civilians. We find, for example, that for the first seven months of this year, diseases of the motor system accounted for 12.5 per cent of the discharges, diseases of the digestive system, 5.4 per cent, diseases of the respiratory system, 4.6 per cent, diseases of the circulatory system 4.4 per cent, and others in smaller percentages. These conditions, and the problems they will present after separation from the service, are not significantly different from those encountered in normal practice.

There is, however, one category which does depart significantly from civilian expectation, and therefore deserves special attention. I refer to the psychoneuroses, which, since the beginning of the war, have accounted for 25.8 per cent of all medical discharges, with a current rate of over 30 per cent. There is much public concern over these figures, so much that one might almost gain the impression that an entire generation of neurotics was expected to result from this war.

One clue to the proper evaluation of these data may be found in the fact that, in 1944, the neuropsychiatric admissions ascribed to naval service were only one half as many as those considered to have existed prior to enlistment. In other words, the radical disruption of habitual patterns of existence, plus the added strains of combat and of prolonged operation, combined to increase by only one half the psychoneuroses already existing among a rather carefully screened group.

Another consideration which, if it were properly appreciated, would make the situation appear much less alarming, is the great difference between the degree of mental health required in the naval service and that required for civilian life. Not only are the pressures of danger and fatigue far less in ordinary life, but the demands of discipline and conformity, in addition to being less stringent, are met gradually in the process of growing up, while the adjustment to military life must be made abruptly. And the standards for retention also reflect the fact that Naval personnel must be able to carry out their duties with the highest efficiency under conditions of stress such as are seldom encountered apart from combat.

It is therefore not surprising that a much higher percentage of maladjustment should develop among service personnel, nor is it a matter for great concern, from the civilian viewpoint, that such large numbers should be found mentally unfit for military life. Like those rejected from the service at the time of enlistment, those discharged because of psychoneurosis will, in the great majority of instances, find little difficulty in readjusting themselves to normal living. Some two-thirds of them are probably in no worse condition than before their service, at which time they showed no obvious symptoms of maladjustment, and the remaining third owe their difficulties to stresses which few of them will encounter again.

Indeed, the part played by the higher standards of military service is an important one to evaluate in relation to all categories of medical discharges, for physical reasons as well as mental. It is not the physical demands of routine duty which determine these standards, but those which the man must be prepared to meet in an emergency. There is no place in the Navy, for a man who will not be able to do his job under prolonged tension, if necessary for days with only fragmentary rest, and in spite of adverse conditions of weather or battle damage. It is hardly reasonable to assume that failure to meet such standards should disqualify him for the routine performance of a civilian job.

In general, then, the conditions which result in the great majority of discharges from the Naval Service are not significantly different, in nature or severity, from those which might have occurred had the individuals concerned remained in civil life, nor do their consequences take on any special significance, from a medical point of view, because they were incurred during service. In fact, it may not be unduly optimistic to predict that, because of the policy of retention in the hospital until maximum

benefit has been obtained, and because of the advances in rehabilitation techniques, the sequelae of these conditions may be less than would be anticipated under normal conditions.

The fact that the problems of military medicine parallel, to such a great extent, those of civilian practice suggests that the program of rehabilitation, which has contributed so much to the benefits of hospitalization in the services, might be equally applicable not only to the care of veterans after leaving the service, but to the care of civilians as well. There is, in fact, an increasingly evident trend in this direction, as exemplified by the work of the Baruch Committee on Physical Medicine, and its proposal for the establishment of community centers to coordinate and amplify the civilian services of rehabilitation.

Such a program, coordinating the existing social service, of rehabilitating, counseling, and placement activities, with the medical services of the community, could extend to the civilian the type of integrated rehabilitation service now being given by the armed forces. In such a program, the physicians of the community, with their undertsanding of both the capabilities and the limitations of the handicapped, and of the varied psychological factors involved, can play a leading role.

A program of this nature seems highly desirable for the veteran as well. For while the functions of the Veterans Administration are clearly needed in the provision of hospital care and education or vocational training, it is believed that the goal of rehabilitation can best be met if as many as possible of its functions are carried out in the local community, where they will be most readily accessible to the veteran, and where the veteran will tend to think of himself not as belonging to a special class, dependent on the government, but as an ordinary member of the community, with essentially the same problems and needs as his friends and neighbors.

The problem of placement of the handicapped has received renewed attention in this war, with an added impetus from the prolonged shortage of labor. The results of rehabilitation have inspired more comprehensive study of the physical demands of various jobs and of the capabilities of the handicapped than had previously been made. It has come to be recognized that a specific handicap will interfere with only certain specific functions, and that in a job which does not demand those functions, the so-called handicap makes little or no difference. I am impressed by a sentence from a pamphlet prepared by the AC Spark Plug Division of General Motors, which expresses a thought that cannot be too often repeated: "Regardless of the nature of his physical or mental limitation, a man is not 'handicapped' on his job if he is able to perform his work in a satisfactory manner." I recall in this connection a patient at Bethesda, with transverse myelitis, who was on the point of returning to his home town to go into business as a watchmaker; and of another at Philadelphia, with transverse myelitis and blind as well, who, even in spite of these overpowering handicaps, was nevertheless happily doing creditable work in a machine shop.

It is coming to be recognized that the handicapped as a group offer no more risk of additional injury than do their fellow workers, a realization now being reflected in that least sentimental of evaluations, the premium rates of insurance companies.

Connecticut is a highly industrialized State, one in which the medical profession can accomplish much for the handicapped whether they be veterans or other civilians by calling the attention of employers to their capabilities, and assisting medically in this proper placement.

The veteran who has received a disability in service will receive a pension proportionate to his disability to compensate for the limitation on the scope of his activities and this is as it should be. But the greatest service which can be rendered these men, and one in which the medical profession can make a great contribution, is to assist them toward the goal of economic independence. This will do more than any single factor to give them a feeling of self-confidence and self-reliance, a feeling that they are once again able to stand before the world on their own merits.

# PSYCHIATRIC ASPECTS OF VETERANS RE-EMPLOYMENT

C. Charles Burlingame, m.d., *Hartford*

In the final analysis, all of us who have seen service in this war, the last war, or any other war, are veterans, and in speaking of social and medical veteran services, we are talking about services to our own numbers. It is very easy to dissipate the relationship we enjoyed with men while we were in the service, so I am very happy to see the re-marriage between the Veterans Facility and the State Medical Society. We were all married during the war years.

First, I would like to call to your attention the biggest problem facing the Veterans Administration and the public today—this much talked of and pushed around "N.P." situation. At the induction line, it was revealed that there were apparently only a relatively small number of rejectees who merited being outside rather intimate psychiatric care. As time went on, the dischargees from the armed forces for neuropsychiatric reasons were very widely advertised, and statements were made of all the horrible things resulting from these neuropsychiatric disabilities which were inflicted upon the citizen soldier. As a matter of fact, it is not an exaggeration to say that the problem has been emphasized to the extent of convincing most people that we are a nation of psychoneurotics, screwballs, and what have you. All this, which I took at face value, I found very interesting.

Along with the rest of the nation, industrialists read in the newspapers that the year 1944 would produce a million neuropsychiatric cases from the armed forces. They also read that industry would be required by law to reassimilate these people, and along with so many others, the industrialists began to get a little jittery. As a result, I was called in to determine ways of protecting industry's equipment, and of protecting industry's employees, particularly the presidents, from having their heads shot off by some lunatic soldier discharged from the armed services.

I confess I started in with the assumption that there was a tremendous problem. I spent approximately a year investigating little industries employing 200, to industries employing 100,000 or more but I had not gone far before I began to have some difficulty in finding any problem.

With a little study, it became quite evident that if a veteran came home, and punched somebody or went berserk, or something of that kind, it was front page news. Similar things have been going on at least since I became a psychiatrist, and that was thirty-seven years ago. In the past, they would sometimes make the front page, but in the larger cities, they were usually relegated to the back pages, or were not printed at all. The differentiating factors during war time were that the individuals were veterans and a psychiatric panic had just passed over the country; therefore, the stories were "good" news.

I endeavored to discover just how such occurrences compared in proportion to the expectancy in civilian life. It was a difficult thing to determine but I distinctly obtained the impression that these overt acts of some service people were no greater than had been occurring in civilian life. The only difference was that the service people had the distinguishing mark of being a specialized group.

I also studied this problem in another capacity when I was called to make an inspection tour across the country with the Secretary of War General Staff. It was military, and somewhat in confidence so there are many facts which I am not at liberty to divulge. However, I feel that I can tell you, and I think you should know that the greater percentage of men discharged from the armed forces as psychoneurotics never left continental United States. It is reasonable to assume that in civilian life they would not have been labelled as psychoneurotic, and that they would not have needed a doctor's treatment. The root of the whole problem lay in the fact that these people were essentially not the military type

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

and in military circumstances, they reacted in a neurotic manner.

If you will bear with me a moment, I would like to be pedantic. It has been said in some quarters that a psychoneurosis is one of the luxuries of a lush civilization. I, myself, would hardly go that far. However, if there be a modicum of truth in that statement, it is worth while for us to consider it.

In civilian life, a man who has a little difficulty in his domestic relationships can juggle things around until they are accommodated to his peculiarities. Perhaps he can have a bedroom by himself, or with somebody else, or something. At any rate, his particular likes and dislikes, quirks, and peculiarities can be given tougher consideration, and he is able to make the grade very nicely.

On the other hand, those of you who have been in the Army know that occasional difficulties arise as to the matter of a soldier, or even an officer, fitting the existing domestic relationship to his neurotic nicety. He may find it difficult, as many men do, to sleep in barracks, and to undress and appear in the September-morn state before his fellowmen.

It is clearly seen that the domestic relationship is easily adjustable in civilian life, as opposed to Army life, wherein it is frozen. However, should a man fail to make the adjustment in the Army, he would probably exhibit a neurotic reaction to that particular, and hence, be labelled psychoneurotic. The solution to the problem, and subsequently, the "cure," is obviously severance from the service. He does not need "special handling" from his friends and acquaintances. He does not need psychoanalytic procedure. He only needs to get back into the swing of his civilian existence.

Another circumstance which is common to all is the social relationship. As civilians, one man will like to bowl, and another will prefer listening to the radio. Another can't stand the radio, but enjoys himself thoroughly with a good book. Another one may want to do something else, but each has the freedom of choice and execution. Here again, those of you who have been in the Army know that it is not easy to adapt yourself to the social circumstances of the armed services. You get just what is handed to you, within very narrow limits, and similarly, if a man can't take it, he may react in a neurotic manner. Obviously, he is not sick in the civilian sense at all. He does not need a psychiatrist; he needs to be released from the Army and be shoved back into civilian life where those factors are controllable.

A third factor is the sexual side, which follows the same pattern as the two I have already mentioned. The sexual circumstances which may be very easily and properly adjusted in civilian life, are not equally flexible in the armed services, and some men react in a neurotic manner.

The fourth important factor is the job relationship. How many men could stand to be scooped in, lined up, and told, "You're bank clerks." They couldn't take it, and some of them would react in a neurotic way. It may give them a pain in the neck, figuratively, and sometimes literally. Because the man is the wrong person for the job, it may give him headaches or dizzy spells. Fortunately, such is not the case. A man has a choice of jobs, and he may choose one, and then try another until he finds one which he can do. Few, indeed, are the people who, in civilian life, are able to do any job into which they happen to be thrown, and luckily, civilian life is malleable enough to fit individual differences.

None of you who have seen a Top Sergeant in action would ever argue that a G. I. has much of a choice as to what he will or will not do! Sometimes they can't take it, they react in a neurotic way, and the answer lies in getting out of the Army and back where more flexible conditions offer greater opportunity in making adjustments.

So it is that I have tried to draw for you the picture of these four broad particulars governing a man's life; I have tried to show you how the military adjustment varies from the civilian, and to explain to you why the problem must be considered in the light of this single sentence: These men were not soldier material, but they had been perfectly good civilian material, and except as we give emphasis to the problem, they are equally able to readjust, and do a good job of it. Not being soldier material, they were not good Army subjects, but nothing in the Army changed their civilian ability.

It is in ignorance of those facts that we may be at fault. If we look curiously at dischargees and say, "Oh, you're out of the Army; you're psychoneurotic," they being somewhat delicately balanced, are convinced in their minds that they *are* invalids. Poisoned by the prevailing opinion, they may have a sense of guilt or shame at having been diagnosed as psychoneurotic. Obviously, there is no compensation—dollars and cents, benefits, or funds of any kind—that will compensate for their right to be a healthy, dynamic force in this community.

Most of these chaps are going to come into your hands, and not into the hands of a psychiatrist. Furthermore, the bulk of the problem, and the stopping of the psychiatric panic will be up to you. Therefore, I urge you to use a little intelligent, common sense, and say to these dischargees who have a good work history, "Old man, we know all about this psychoneurosis stuff. It may have been true in the service, but it only means you weren't born to be a soldier in this particular war." Explain to them as I have tried to explain to you, that they should be reassured, and given a pat on the back. "Go back to work, old thing, you're okay. You don't need to see a psychiatrist."

As a matter of fact, most psychiatrists feel as I am telling you. We believe it is too bad to have the men reach us unless it is absolutely necessary, and the vast majority of these fellows should be stopped before they ever get to us.

I would like to emphasize the fact that I have been speaking of those chaps with a good work history, who have not seen combat. I would be misleading you if I left you with the impression that there is no real, solid psychiatric problem for us to tackle. What I am trying to get across is the denial of any need to be overwhelmed by a psychiatric problem which can be handled with a light touch.

I say the following advisedly: You have read in the paper about half a million military psychiatric cases, but based upon civilian standards, the psychotic or frank mental breakdowns in this war have been less, on a percentage basis, than in the same age group in civilian life. Just think that over, disregarding the nebulous psychoneurosis, escape mechanism, or whatever you wish to call it. Why don't we see those facts spread over the newspapers? Why isn't that news? I am far more impressed with the ability to take it and the stamina shown by our armed forces, than I am by these stories about the mass of mental breakdowns.

I am very tired of hearing that our men are coming back knocked to pieces in body and mind, that they are all going to be wrecks, and need to be adjusted. I am tired of hearing that every wife should be buying books and taking some courses in psychology, that she should take a telescope to see her darling come down the line, look through the telescope, and see whether the hind leg isn't swinging a little differently. Of course, it's swinging differently! He is more of a man than when he went away! If we turn the telescope on the wife, she probably couldn't stand it half as well as he coul so let's get back to sense.

These chaps are going to go through a period c adjustment, but why call it "psychiatric?"

If you go on a vacation, doctor, for six weeks c two months, the old office will look a bit queer an unfamiliar to you when you come back. You wi feel a little strange in your own bailiwick, as thoug things were not quite the same. If you don't fe like that, your vacation didn't do you any good.

These chaps who have been away for much mor than a month or two, are coming back, and the are going to feel strange, but that does not make psychiatric.

I was called upon to examine some men who cam from Attu, and since it is more interesting to mak it specific, I shall tell you about one in particula He had been there 21 months in that fog; 21 month in the fog, and not off the island. He made th grade and did very well, until he got back to Seattl where he got hotel rooms through the U.S.O., o some other effective organization. Everythin seemed strange. He would go out and buy a pack age of cigarettes, and walk right back into thi room and stay there. He got a lot of attention. The almost sent him to a closed ward of an Army Gen eral Hospital.

Well, I talked to this chap. In the first place, h must have been a darned stable individual to tak those 21 months without blowing a fuse. I know would have blown it. If he had been able to adjus in half an hour without feeling strange on the wa back to civilization, then he would have been screwball! What he was having was a perfectl normal reaction to the circumstances. Why make i psychiatric?

Talking to this chap, I said, "There is nothin wrong with you. You had a hard time adjusting t that life. You are going to have a merry time adjust ing to your old life. You will do in hours and day what it took you weeks and months to do there. Six weeks later I heard from the fellow, "Oh, I'r swell, doc, but I thought for a while they had m labelled a screwball."

All this has been for one purpose—to remind yo not to lose your common sense just because we hav had a war, and just because the psychiatric aspec has been so well advertised. You yourselves ca liquidate many of the problems. You can reassur these chaps, and if a specialist is not necessary, yo can be a very stabilizing influence. Many of ther

will need to go to a psychiatrist, but with a light touch, you can do a great deal of the work. Again, I am speaking largely of those men who never went overseas, and never saw combat, those who previously had a good, stable work history.

I have only one thing more, and it concerns those men who did extremely well in the Army and were the best of the bunch in combat, who left civilian life 100 per cent behind to identify themselves 100 per cent with the armed forces and their objectives. Those are the boys who may have the real difficulty in their readjustment to civilian life, not those who never did actually get into the fray. Those who never got into it kept one foot on the old familiar ground, and did not completely divorce themselves from civilian life. They may have less trouble getting back into the swings of things than those who went in and saw combat—and how they did see it—and lost themselves in the objectives of the Army. Those heroes and "good soldiers" are not going to be discharged as N.P. cases, or for any other medical reason, but they may need some real help. Be on the lookout for them.

# TUBERCULOSIS AS AN AFTERMATH OF THE WAR

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In order to understand or to analyze the problem of tuberculosis in the post war period, it is necessary to understand the situation that existed in Connecticut just prior to and during the war. For the benefit of those who have not followed the situation in Connecticut closely, I shall briefly review these two periods, for the outlook for the control of tuberculosis in the post war period has been markedly altered by war-time experiences.

As the figures indicate, there has been a slight increase in the death rate from 32.6 in 1939 to 35.3 in 1944. The increase has not been appreciable and I do not think it is particularly significant. These figures are based on the estimated population of the State. Really accurate figures are impossible to secure, because of the influx of people from out of the State.

The number of new cases reported has shown a marked increase and some fluctuation during the course of the war. This is quite explainable on the basis of mass chest x-ray surveys at Induction Centers and in industry with a find ranging from 1,184 in 1939, reaching a peak in 1942 of 1,584 when induction into the Armed Services was greatest,

Tuberculosis Statistics—Connecticut

| | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 |
|---|---|---|---|---|---|---|
| Number of deaths | 586 | 582 | 577 | 608 | 591 | 619 |
| Deaths per 100,000 population | 32.6 | 34.0 | 33.5 | 35.1 | 33.9 | 35.3 |
| New cases reported | 1184 | 1221 | 1325 | 1584 | 1280 | 1372 |
| JULY 1939 – JUNE 1945 | 1939-40 | 1940-41 | 1941-42 | 1942-43 | 1943-44 | 1944-45 |
| Sanatorium admissions | 1156 | 1318 | 1343 | 1376 | 1343 | 994 |
| Per cent in minimal stage | 9.5 | 9.2 | 15.3 | 14.0 | 11.8 | * |
| Sanatorium discharges, including deaths | 934 | 1273 | 1338 | 1390 | 1412 | 1136 |
| Number leaving against advice | 127 | 239 | 253 | 273 | 307 | 255 |
| Per cent leaving against advice | 13.6 | 18.8 | 18.9 | 19.6 | 21.7 | 22.4 |

*This information is not yet available (September 1945).

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

dropping off in 1943 and a slow rise in 1944 when industrial surveys got well under way. These figures do not represent all the new cases found during this period because not all cases are reported.

The sanatorium admissions simply reflect the new cases reported except for 1944 when a marked decrease in sanatorium admissions occurred. I believe there are several explanations for this decrease of admissions in 1944. In 1942 many of the new cases reported came as a result of Induction Center examinations. The percentage of significant lesions found in this group was high, whereas the high figure of cases found in 1944 was due in a large part to industrial surveys. In industry the number of cases found is considerably higher than that found among selectees, 0.7 per cent for selectees and 1.5 per cent in industry, but of the cases found in industry a relatively small number have significant lesions requiring sanatorium care; roughly 50 per cent in selectees and 30 per cent in industry.

As for the steady increase in patients leaving against advice from 13.6 per cent in 1939 to 22.4 per cent in 1944-45, there are again several explanations. High wages not only deter patients with active tuberculosis from entering sanatoria but they precipitate patients to leave against advice. There has been a considerable increase in the number of early symptom-free cases admitted during this period and it is extremely difficult to convince such patients either to enter a sanatorium for treatment, or once admitted to remain a sufficient length of time to effect a "cure." Many such cases who refused to enter sanatoria during the war or left against advice will be applying for sanatorium admission in the post war period.

No state-wide usable case register has ever been available in Connecticut. However, such a register is now in the process of being set up. This is necessary if, a system of follow up of cases found is to be effective.

Consultation services throughout the State as a whole were few in number, inadequate in equipment and personnel, and were not readily available. Their organization was poor. As a result, they were not used nearly to the extent that they might have been. This constitutes, in my opinion, another reason why such a small percentage of minimal cases, found during the last four years, have been advised to seek sanatorium care. Plans are now in progress to correct this lack of an adequate consultation service.

Treatment and the facilities for this are excellent in Connecticut but the number of beds available fo use are inadequate.

Chemotherapy, about which we have heard s much during the war, has been extensively investi gated in relation to tuberculosis. Thus far, its valu in the treatment of tuberculosis has not been proved except as it has been used in relation to some of th complications of tuberculosis, e.g., empyema occur ring as a complication of pneumothorax treatments

The results of treatment are disappointing for th very obvious reason that about 85 per cent of thos admitted are in an advanced stage of the disease many deaths occurring within a few hours afte admission. A considerable number of cases have bee transferred to our sanatoria in a moribund state During the course of the war there has been gradual reduction in the percentage of advance cases being admitted and a gradual but limited in crease in minimal cases admitted. However, thi situation has not improved nearly as much as i should have considering the number of minimal case found. (78 per cent of cases found in industry are i a minimal stage of disease.)

Since 1939, the number of state sanatorium bed have increased from 1,127 to 1,610. The estimate total number of beds in the state in 1944, including all sanatoria, was 1,750, a ratio of 2.8 beds per death

There has been a waiting list in the state sanatoria from time to time before the war, during the war and at present, for various reasons. The two mai reasons for waiting lists during the war have bee the marked increase of patients seeking sanatorium care and the lack of personnel to staff the institutions. Were it not for the fact that 12 per cent o all admissions were mistakenly diagnosed as tuberculosis and were fairly promptly discharged, and that an average of 20 per cent left against advice there would have been a continuous and substantia waiting list.

The sanatoria have, during the war, experienced great difficulty in securing sufficient help, particularly nursing personnel. That they have been able to manage under the circumstances and prevent closing large sections of the sanatoria and thereby creating a long waiting list, as has occurred in some states, required no small amount of careful planning on the part of the Tuberculosis Commission and the Sanatoria Superintendents.

The post war period should relieve this situation although there is no immediate relief in sight, and as a matter of fact, the help situation is worse now,

hiladelphia and at Mare Island. The guillotine, or pen circular method has been the standard amputaon under field conditions. Preservation of all able tissue possible was enjoined along with mainnance of skin traction constantly during evacuaon, to prevent retraction. Revision is done at the enters, where the most suitable final amputation can e chosen by surgeons who have had exercisive exerience in this work. The various physical medicine rocedures are employed to condition the stump, evelop its remaining musculature, eliminate or void contractures, and to develop the rest of the ody to accept a compensatory burden. The artiial limbs are manufactured in the shops in these enters for the individual patient who will use them nd they incorporate improvements developed as a sult of research in these and other hospitals. The mbs are fitted as soon as the stump has healed, so nat the period of stump shrinkage may be employed or training in their use. Refitting and adjustment done as necessary as shrinkage progresses. Trainng is continued until the amputee has successfully assed an achievement test, covering a wide variety f representative activities which demonstrate his ility to meet the varied demands of ordinary life.

A striking example of the results which may be chieved is to be found in the care of cord bladder ases, for whom a center has recently been estabshed at U. S. Naval Hospital, Santa Margarita anch, Oceanside, California. Normal voluntary nction cannot of course be regained unless some erve pathways remain, but such measures as exloration of the cauda equina for scar tissue, and ntensive retraining, do succeed in restoring more or ss function to some cases which at first sight ppear hopeless. The majority, however, can only arn to compensate indirectly for their disability. Iaximum physical development and training in the se of caliper braces and crutches enables many a an to overcome the utter helplessness which would rmerly have been his lot. Regular physical exercise ays invaluable dividends in avoiding decalcification f bones and the formation of urinary calcula. A ransurethral operation for the removal of hyperophide tissue from the neck of the bladder gives romise of eliminating one of the most distressing eatures of this condition—the need for continual atheterization.

In the centers, as well as in all hospitals and, as far s possible, in the units overseas, a rehabilitation rogram is carried out for the benefit not only of the permanently handicapped but of all patients, whatever their condition.

The underlying philosophy is that of treating the patient as a whole, as distinguished from merely treating his illness or injury. Physical training consistent with his condition avoids the weakness and atrophy commonly associated with prolonged hospitalization. Physical therapy and occupational therapy are used to the maximum for the restoration of lost function. Education, often carrying academic credit, and vocational training, both theoretical and practical, help prevent the usual mental inertia and loss of morale, direct the patient's attention to the future instead of the present, and help to prepare him for his life after he leaves the hospital, whether he returns to duty or to civil life. Those who will leave the service are offered legal and social services, as well as vocational counseling and an explanation of their rights and benefits as veterans.

The goal then is to restore all patients, whether handicapped or not, to an optimum state not only of physical health, but of social and economic preparation for the future. No patient is discharged from the service until he is considered to have received the maximum benefit from hospitalization, except those who require prolonged care and are transferred to a Veterans Administration facility. Since the criterion for discharge from the service is attainment of maximum benefit from a medical standpoint, education and vocational training are, of necessity, limited to the time available while under treatment. It is not the purpose of the Medical Department to assume the functions of the Veterans Administration in this regard, but simply to assist the patient to get whatever head start he can in the time at his disposal. In the case of the specially handicapped, the concept of maximum benefit is held to require rehabilitation to the point where the patient will be able, if he so desires, to carry on without further aid, though he is of course encouraged to avail himself to all further assistance which will be of immediate or ultimate benefit to him.

Let us now refer briefly to the statistics of discharges for physical disability from the Navy, Marine Corps, and Coast Guard, to see what light they may throw on the nature and magnitude of the medical problems of veterans. In the period of January 1942, through July 1945, there were 240,271 men and women so discharged from the Service. From an initial level of about 1,600 per month, this rate has steadily increased so that we are now discharging in

the neighborhood of 15,000 monthly, one half of two thirds of them for service-connected disabilities.

There is a natural tendency, when thinking of medical discharges, to think of them as largely due to combat injuries. We find, however, that current figures, which most accurately reflect the ultimate total, show that less than 5 per cent are the result of injuries, including those received in the course of every day pursuits as well as in combat. We can now make a rough prediction of the total numbers of certain categories of the handicapped to be expected as a result of this war: the blind will probably not number more than 200, the deaf perhaps 3,000, and amputations of an extremity in the neighborhood of 2,200. In relation to the overall numbers, then, it will be seen that these conditions represent but a small fraction of the total.

By and large, the causes for medical discharge from the Service are those conditions which occur also, and with similar frequency, in comparable age groups among civilians. We find, for example, that for the first seven months of this year, diseases of the motor system accounted for 12.5 per cent of the discharges, diseases of the digestive system, 5.4 per cent, diseases of the respiratory system, 4.6 per cent, diseases of the circulatory system 4.4 per cent, and others in smaller percentages. These conditions, and the problems they will present after separation from the service, are not significantly different from those encountered in normal practice.

There is, however, one category which does depart significantly from civilian expectation, and therefore deserves special attention. I refer to the psychoneuroses, which, since the beginning of the war, have accounted for 25.8 per cent of all medical discharges, with a current rate of over 30 per cent. There is much public concern over these figures, so much that one might almost gain the impression that an entire generation of neurotics was expected to result from this war.

One clue to the proper evaluation of these data may be found in the fact that, in 1944, the neuropsychiatric admissions ascribed to naval service were only one half as many as those considered to have existed prior to enlistment. In other words, the radical disruption of habitual patterns of existence, plus the added strains of combat and of prolonged operation, combined to increase by only one half the psychoneuroses already existing among a rather carefully screened group.

Another consideration which, if it were properly appreciated, would make the situation appear much less alarming, is the great difference between th degree of mental health required in the naval serv ice and that required for civilian life. Not only ar the pressures of danger and fatigue far less in ordi nary life, but the demands of discipline and con formity, in addition to being less stringent, are me gradually in the process of growing up, while th adjustment to military life must be made abruptly And the standards for retention also reflect the fac that Naval personnel must be able to carry out thei duties with the highest efficiency under condition of stress such as are seldom encountered apart fror combat.

It is therefore not surprising that a much highe percentage of maladjustment should develop amon service personnel, nor is it a matter for great con cern, from the civilian viewpoint, that such larg numbers should be found mentally unfit for militar life. Like those rejected from the service at the tim of enlistment, those discharged because of psycho neurosis will, in the great majority of instances, fin little difficulty in readjusting themselves to norma living. Some two-thirds of them are probably in n worse condition than before their service, at whic time they showed no obvious symptoms of malad justment, and the remaining third owe their diff culties to stresses which few of them will encounte again.

Indeed, the part played by the higher standard of military service is an important one to evaluat in relation to all categories of medical discharges, fo physical reasons as well as mental. It is not the physi cal demands of routine duty which determine thes standards, but those which the man must be pre pared to meet in an emergency. There is no place i the Navy, for a man who will not be able to do hi job under prolonged tension, if necessary for day with only fragmentary rest, and in spite of advers conditions of weather or battle damage. It is hardl reasonable to assume that failure to meet such stand ards should disqualify him for the routine perform ance of a civilian job.

In general, then, the conditions which result i the great majority of discharges from the Nava Service are not significantly different, in nature o severity, from those which might have occurred ha the individuals concerned remained in civil life, no do their consequences take on any special signi ficance, from a medical point of view, because the were incurred during service. In fact, it may not b unduly optimistic to predict that, because of th policy of retention in the hospital until maximur

enefit has been obtained, and because of the ad-ances in rehabilitation techniques, the sequelae of nese conditions may be less than would be antici-ated under normal conditions.

The fact that the problems of military medicine arallel, to such a great extent, those of civilian prac-ice suggests that the program of rehabilitation, vhich has contributed so much to the benefits of ospitalization in the services, might be equally pplicable not only to the care of veterans after eaving the service, but to the care of civilians as vell. There is, in fact, an increasingly evident trend n this direction, as exemplified by the work of the Baruch Committee on Physical Medicine, and its proposal for the establishment of community centers o coordinate and amplify the civilian services of ehabilitation.

Such a program, coordinating the existing social ervice, of rehabilitating, counseling, and placement ctivities, with the medical services of the com-nunity, could extend to the civilian the type of ntegrated rehabilitation service now being given by he armed forces. In such a program, the physicians of the community, with their undertsanding of both he capabilities and the limitations of the handi-apped, and of the varied psychological factors in-olved, can play a leading role.

A program of this nature seems highly desirable or the veteran as well. For while the functions of he Veterans Administration are clearly needed in he provision of hospital care and education or voca-ional training, it is believed that the goal of rehabili-ation can best be met if as many as possible of its unctions are carried out in the local community, where they will be most readily accessible to the eteran, and where the veteran will tend to think of imself not as belonging to a special class, depend-nt on the government, but as an ordinary member of the community, with essentially the same prob-ems and needs as his friends and neighbors.

The problem of placement of the handicapped has received renewed attention in this war, with an added impetus from the prolonged shortage of labor. The results of rehabilitation have inspired more comprehensive study of the physical demands of various jobs and of the capabilities of the handicapped than had previously been made. It has come to be recognized that a specific handicap will interfere with only certain specific functions, and that in a job which does not demand those functions, the so-called handicap makes little or no difference. I am impressed by a sentence from a pamphlet prepared by the AC Spark Plug Division of General Motors, which expresses a thought that cannot be too often repeated: "Regardless of the nature of his physical or mental limitation, a man is not 'handicapped' on his job if he is able to perform his work in a satisfactory manner." I recall in this connection a patient at Bethesda, with transverse myelitis, who was on the point of returning to his home town to go into business as a watchmaker; and of another at Philadelphia, with transverse myelitis and blind as well, who, even in spite of these overpowering handicaps, was nevertheless happily doing creditable work in a machine shop.

It is coming to be recognized that the handicapped as a group offer no more risk of additional injury than do their fellow workers, a realization now being reflected in that least sentimental of evaluations, the premium rates of insurance companies.

Connecticut is a highly industrialized State, one in which the medical profession can accomplish much for the handicapped whether they be veterans or other civilians by calling the attention of employers to their capabilities, and assisting medically in this proper placement.

The veteran who has received a disability in service will receive a pension proportionate to his disability to compensate for the limitation on the scope of his activities and this is as it should be. But the greatest service which can be rendered these men, and one in which the medical profession can make a great contribution, is to assist them toward the goal of economic independence. This will do more than any single factor to give them a feeling of self-confidence and self-reliance, a feeling that they are once again able to stand before the world on their own merits.

# PSYCHIATRIC ASPECTS OF VETERANS RE-EMPLOYMENT

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In the final analysis, all of us who have seen service in this war, the last war, or any other war, are veterans, and in speaking of social and medical veteran services, we are talking about services to our own numbers. It is very easy to dissipate the relationship we enjoyed with men while we were in the service, so I am very happy to see the remarriage between the Veterans Facility and the State Medical Society. We were all married during the war years.

First, I would like to call to your attention the biggest problem facing the Veterans Administration and the public today—this much talked of and pushed around "N.P." situation. At the induction line, it was revealed that there were apparently only a relatively small number of rejectees who merited being outside rather intimate psychiatric care. As time went on, the dischargees from the armed forces for neuropsychiatric reasons were very widely advertised, and statements were made of all the horrible things resulting from these neuropsychiatric disabilities which were inflicted upon the citizen soldier. As a matter of fact, it is not an exaggeration to say that the problem has been emphasized to the extent of convincing most people that we are a nation of psychoneurotics, screwballs, and what have you. All this, which I took at face value, I found very interesting.

Along with the rest of the nation, industrialists read in the newspapers that the year 1944 would produce a million neuropsychiatric cases from the armed forces. They also read that industry would be required by law to reassimilate these people, and along with so many others, the industrialists began to get a little jittery. As a result, I was called in to determine ways of protecting industry's equipment, and of protecting industry's employees, particularly the presidents, from having their heads shot off by some lunatic soldier discharged from the armed services.

I confess I started in with the assumption tha there was a tremendous problem. I spent approxi mately a year investigating little industries employ ing 200, to industries employing 100,000 or more but I had not gone far before I began to have som difficulty in finding any problem.

With a little study, it became quite evident tha if a veteran came home, and punched somebody o went berserk, or something of that kind, it was fron page news. Similar things have been going on at leas since I became a psychiatrist, and that was thirty seven years ago. In the past, they would sometime make the front page, but in the larger cities, the were usually relegated to the back pages, or wer not printed at all. The differentiating factors durin war time were that the individuals were veteran and a psychiatric panic had just passed over th country; therefore, the stories were "good" news.

I endeavored to discover just how such occur rences compared in proportion to the expectanc in civilian life. It was a difficult thing to determine but I distinctly obtained the impression that thes overt acts of some service people were no greate than had been occurring in civilian life. The onl difference was the service people had the dis tinguishing mark of being a specialized group.

I also studied this problem in another capacit when I was called to make an inspection tour acros the country with the Secretary of War Genera Staff. It was military, and somewhat in confidence so there are many facts which I am not at liberty t divulge. However, I feel that I can tell you, and think you should know that the greater percentag of men discharged from the armed forces as psycho neurotics never left continental United States. It reasonable to assume that in civilian life they woul not have been labelled as psychoneurotic, and tha they would not have needed a doctor's treatmen The root of the whole problem lay in the fact tha these people were essentially not the military typ

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospita Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medic Society.*

and in military circumstances, they reacted in a neurotic manner.

If you will bear with me a moment, I would like to be pedantic. It has been said in some quarters that a psychoneurosis is one of the luxuries of a lush civilization. I, myself, would hardly go that far. However, if there be a modicum of truth in that statement, it is worth while for us to consider it.

In civilian life, a man who has a little difficulty in his domestic relationships can juggle things around until they are accommodated to his peculiarities. Perhaps he can have a bedroom by himself, or with somebody else, or something. At any rate, his particular likes and dislikes, quirks, and peculiarities can be given tougher consideration, and he is able to make the grade very nicely.

On the other hand, those of you who have been in the Army know that occasional difficulties arise as to the matter of a soldier, or even an officer, fitting the existing domestic relationship to his neurotic nicety. He may find it difficult, as many men do, to sleep in barracks, and to undress and appear in the September-morn state before his fellowmen.

It is clearly seen that the domestic relationship is easily adjustable in civilian life, as opposed to Army life, wherein it is frozen. However, should a man fail to make the adjustment in the Army, he would probably exhibit a neurotic reaction to that particular, and hence, be labelled psychoneurotic. The solution to the problem, and subsequently, the "cure," is obviously severance from the service. He does not need "special handling" from his friends and acquaintances. He does not need psychoanalytic procedure. He only needs to get back into the swing of his civilian existence.

Another circumstance which is common to all is the social relationship. As civilians, one man will like to bowl, and another will prefer listening to the radio. Another can't stand the radio, but enjoys himself thoroughly with a good book. Another one may want to do something else, but each has the freedom of choice and execution. Here again, those of you who have been in the Army know that it is not easy to adapt yourself to the social circumstances of the armed services. You get just what is handed to you, within very narrow limits, and similarly, if a man can't take it, he may react in a neurotic manner. Obviously, he is not sick in the civilian sense at all. He does not need a psychiatrist; he needs to be released from the Army and be shoved back into civilian life where those factors are controllable.

A third factor is the sexual side, which follows the same pattern as the two I have already mentioned. The sexual circumstances which may be very easily and properly adjusted in civilian life, are not equally flexible in the armed services, and some men react in a neurotic manner.

The fourth important factor is the job relationship. How many men could stand to be scooped in, lined up, and told, "You're bank clerks." They couldn't take it, and some of them would react in a neurotic way. It may give them a pain in the neck, figuratively, and sometimes literally. Because the man is the wrong person for the job, it may give him headaches or dizzy spells. Fortunately, such is not the case. A man has a choice of jobs, and he may choose one, and then try another until he finds one which he can do. Few, indeed, are the people who, in civilian life, are able to do any job into which they happen to be thrown, and luckily, civilian life is malleable enough to fit individual differences.

None of you who have seen a Top Sergeant in action would ever argue that a G. I. has much of a choice as to what he will or will not do! Sometimes they can't take it, they react in a neurotic way, and the answer lies in getting out of the Army and back where more flexible conditions offer greater opportunity in making adjustments.

So it is that I have tried to draw for you the picture of these four broad particulars governing a man's life; I have tried to show you how the military adjustment varies from the civilian, and to explain to you why the problem must be considered in the light of this single sentence: These men were not soldier material, but they had been perfectly good civilian material, and except as we give emphasis to the problem, they are equally able to readjust, and do a good job of it. Not being soldier material, they were not good Army subjects, but nothing in the Army changed their civilian ability.

It is in ignorance of those facts that we may be at fault. If we look curiously at dischargees and say, "Oh, you're out of the Army; you're psychoneurotic," they being somewhat delicately balanced, are convinced in their minds that they *are* invalids. Poisoned by the prevailing opinion, they may have a sense of guilt or shame at having been diagnosed as psychoneurotic. Obviously, there is no compensation—dollars and cents, benefits, or funds of any kind—that will compensate for their right to be a healthy, dynamic force in this community.

Most of these chaps are going to come into your hands, and not into the hands of a psychiatrist. Furthermore, the bulk of the problem, and the stopping of the psychiatric panic will be up to you. Therefore, I urge you to use a little intelligent, common sense, and say to these dischargees who have a good work history, "Old man, we know all about this psychoneurosis stuff. It may have been true in the service, but it only means you weren't born to be a soldier in this particular war." Explain to them as I have tried to explain to you, that they should be reassured, and given a pat on the back. "Go back to work, old thing, you're okay. You don't need to see a psychiatrist."

As a matter of fact, most psychiatrists feel as I am telling you. We believe it is too bad to have the men reach us unless it is absolutely necessary, and the vast majority of these fellows should be stopped before they ever get to us.

I would like to emphasize the fact that I have been speaking of those chaps with a good work history, who have not seen combat. I would be misleading you if I left you with the impression that there is no real, solid psychiatric problem for us to tackle. What I am trying to get across is the denial of any need to be overwhelmed by a psychiatric problem which can be handled with a light touch.

I say the following advisedly: You have read in the paper about half a million military psychiatric cases, but based upon civilian standards, the psychotic or frank mental breakdowns in this war have been less, on a percentage basis, than in the same age group in civilian life. Just think that over, disregarding the nebulous psychoneurosis, escape mechanism, or whatever you wish to call it. Why don't we see those facts spread over the newspapers? Why isn't that news? I am far more impressed with the ability to take it and the stamina shown by our armed forces, than I am by these stories about the mass of mental breakdowns.

I am very tired of hearing that our men are coming back knocked to pieces in body and mind, that they are all going to be wrecks, and need to be adjusted. I am tired of hearing that every wife should be buying books and taking some courses in psychology, that she should take a telescope to see her darling come down the line, look through the telescope, and see whether the hind leg isn't swinging a little differently. Of course, it's swinging differently! He is more of a man than when he went away! If we turn the telescope on the wife, she probably couldn't stand it half as well as he coul so let's get back to sense.

These chaps are going to go through a period c adjustment, but why call it "psychiatric?"

If you go on a vacation, doctor, for six weeks c two months, the old office will look a bit queer an unfamiliar to you when you come back. You wi feel a little strange in your own bailiwick, as thoug things were not quite the same. If you don't fe like that, your vacation didn't do you any good.

These chaps who have been away for much mo than a month or two, are coming back, and the are going to feel strange, but that does not make psychiatric.

I was called upon to examine some men who can from Attu, and since it is more interesting to mak it specific, I shall tell you about one in particula He had been there 21 months in that fog; 21 montl in the fog, and not off the island. He made th grade and did very well, until he got back to Seattl where he got hotel rooms through the U.S.O., c some other effective organization. Everythin seemed strange. He would go out and buy a pacl age of cigarettes, and walk right back into th room and stay there. He got a lot of attention. The almost sent him to a closed ward of an Army Ge eral Hospital.

Well, I talked to this chap. In the first place, h must have been a darned stable individual to tak those 21 months without blowing a fuse. I know would have blown it. If he had been able to adju in half an hour without feeling strange on the wa back to civilization, then he would have been screwball! What he was having was a perfectl normal reaction to the circumstances. Why make psychiatric?

Talking to this chap, I said, "There is nothin wrong with you. You had a hard time adjusting t that life. You are going to have a merry time adjus ing to your old life. You will do in hours and day what it took you weeks and months to do there Six weeks later I heard from the fellow, "Oh, I' swell, doc, but I thought for a while they had m labelled a screwball."

All this has been for one purpose—to remind yo not to lose your common sense just because we hav had a war, and just because the psychiatric aspe has been so well advertised. You yourselves ca liquidate many of the problems. You can reassu these chaps, and if a specialist is not necessary, yo can be a very stabilizing influence. Many of the

will need to go to a psychiatrist, but with a light touch, you can do a great deal of the work. Again, I am speaking largely of those men who never went overseas, and never saw combat, those who previously had a good, stable work history.

I have only one thing more, and it concerns those men who did extremely well in the Army and were the best of the bunch in combat, who left civilian life 100 per cent behind to identify themselves 100 per cent with the armed forces and their objectives. Those are the boys who may have the real difficulty in their readjustment to civilian life, not those who never did actually get into the fray. Those who never got into it kept one foot on the old familiar ground, and did not completely divorce themselves from civilian life. They may have less trouble getting back into the swings of things than those who went in and saw combat—and how they did see it—and lost themselves in the objectives of the Army. Those heroes and "good soldiers" are not going to be discharged as N.P. cases, or for any other medical reason, but they may need some real help. Be on the lookout for them.

# TUBERCULOSIS AS AN AFTERMATH OF THE WAR

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In order to understand or to analyze the problem of tuberculosis in the post war period, it is necessary to understand the situation that existed in Connecticut just prior to and during the war. For the benefit of those who have not followed the situation in Connecticut closely, I shall briefly review these two periods, for the outlook for the control of tuberculosis in the post war period has been markedly altered by war-time experiences.

As the figures indicate, there has been a slight increase in the death rate from 32.6 in 1939 to 35.3 in 1944. The increase has not been appreciable and I do not think it is particularly significant. These figures are based on the estimated population of the State. Really accurate figures are impossible to secure, because of the influx of people from out of the State.

The number of new cases reported has shown a marked increase and some fluctuation during the course of the war. This is quite explainable on the basis of mass chest x-ray surveys at Induction Centers and in industry with a find ranging from 1,184 in 1939, reaching a peak in 1942 of 1,584 when induction into the Armed Services was greatest,

Tuberculosis Statistics—Connecticut

| | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 |
|---|---|---|---|---|---|---|
| Number of deaths | 586 | 582 | 577 | 608 | 591 | 619 |
| Deaths per 100,000 population | 32.6 | 34.0 | 33.5 | 35.1 | 33.9 | 35.3 |
| New cases reported | 1184 | 1221 | 1325 | 1584 | 1280 | 1372 |
| JULY 1939 – JUNE 1945 | 1939-40 | 1940-41 | 1941-42 | 1942-43 | 1943-44 | 1944-45 |
| Sanatorium admissions | 1156 | 1318 | 1343 | 1376 | 1343 | 994 |
| Per cent in minimal stage | 9.5 | 9.2 | 15.3 | 14.0 | 11.8 | * |
| Sanatorium discharges, including deaths | 934 | 1273 | 1338 | 1390 | 1412 | 1136 |
| Number leaving against advice | 127 | 239 | 253 | 273 | 307 | 255 |
| Per cent leaving against advice | 13.6 | 18.8 | 18.9 | 19.6 | 21.7 | 22.4 |

*This information is not yet available (September 1945).

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

dropping off in 1943 and a slow rise in 1944 when industrial surveys got well under way. These figures do not represent all the new cases found during this period because not all cases are reported.

The sanatorium admissions simply reflect the new cases reported except for 1944 when a marked decrease in sanatorium admissions occurred. I believe there are several explanations for this decrease of admissions in 1944. In 1942 many of the new cases reported came as a result of Induction Center examinations. The percentage of significant lesions found in this group was high, whereas the high figure of cases found in 1944 was due in a large part to industrial surveys. In industry the number of cases found is considerably higher than that found among selectees, 0.7 per cent for selectees and 1.5 per cent in industry, but of the cases found in industry a relatively small number have significant lesions requiring sanatorium care; roughly 50 per cent in selectees and 30 per cent in industry.

As for the steady increase in patients leaving against advice from 13.6 per cent in 1939 to 22.4 per cent in 1944-45, there are again several explanations. High wages not only deter patients with active tuberculosis from entering sanatoria but they precipitate patients to leave against advice. There has been a considerable increase in the number of early symptom-free cases admitted during this period and it is extremely difficult to convince such patients either to enter a sanatorium for treatment, or once admitted to remain a sufficient length of time to effect a "cure." Many such cases who refused to enter sanatoria during the war or left against advice will be applying for sanatorium admission in the post war period.

No state-wide usable case register has ever been available in Connecticut. However, such a register is now in the process of being set up. This is necessary if, a system of follow up of cases found is to be effective.

Consultation services throughout the State as a whole were few in number, inadequate in equipment and personnel, and were not readily available. Their organization was poor. As a result, they were not used nearly to the extent that they might have been. This constitutes, in my opinion, another reason why such a small percentage of minimal cases, found during the last four years, have been advised to seek sanatorium care. Plans are now in progress to correct this lack of an adequate consultation service.

Treatment and the facilities for this are excellent in Connecticut but the number of beds available fo use are inadequate.

Chemotherapy, about which we have heard s much during the war, has been extensively invest gated in relation to tuberculosis. Thus far, its valu in the treatment of tuberculosis has not been prove except as it has been used in relation to some of th complications of tuberculosis, e.g., empyema occu ring as a complication of pneumothorax treatment

The results of treatment are disappointing for th very obvious reason that about 85 per cent of thos admitted are in an advanced stage of the diseas many deaths occurring within a few hours aft admission. A considerable number of cases have bee transferred to our sanatoria in a moribund stat During the course of the war there has been gradual reduction in the percentage of advance cases being admitted and a gradual but limited in crease in minimal cases admitted. However, th situation has not improved nearly as much as should have considering the number of minimal cas found. (78 per cent of cases found in industry are i a minimal stage of disease.)

Since 1939, the number of state sanatorium bec have increased from 1,127 to 1,610. The estimate total number of beds in the state in 1944, includin all sanatoria, was 1,750, a ratio of 2.8 beds per deat

There has been a waiting list in the state sanator from time to time before the war, during the wa and at present, for various reasons. The two mai reasons for waiting lists during the war have bee the marked increase of patients seeking sanatoriu care and the lack of personnel to staff the institu tions. Were it not for the fact that 12 per cent o all admissions were mistakenly diagnosed as tube culosis and were fairly promptly discharged, an that an average of 20 per cent left against advic there would have been a continuous and substanti waiting list.

The sanatoria have, during the war, experience great difficulty in securing sufficient help, particu larly nursing personnel. That they have been ab to manage under the circumstances and preve closing large sections of the sanatoria and thereb creating a long waiting list, as has occurred in son states, required no small amount of careful plannin on the part of the Tuberculosis Commission and th Sanatoria Superintendents.

The post war period should relieve this situatio although there is no immediate relief in sight, an as a matter of fact, the help situation is worse nov

the transmission of sound to areas other than the conventional aortic area.

It is admitted that recognition of the characteristic second aortic sound requires an experienced ear just as Dressler and Moskowitz[19] have demonstrated that in obstetrics auscultation requires acuity of hearing at low frequencies, since in certain cases the ear is incapable of detecting fetal heart sounds. Nevertheless, if one is alert to this condition, experience will come with the recognition of individual cases.

The presence of hyperthyroidism or any condition that can cause a tachycardia may produce the characteristic aortic second sound as well as a systolic murmur. This is due to the increased stroke volume which will increase the velocity of the blood at the semilunar valve orifices, thereby producing alteration in the acoustic qualities. Under such conditions both the aortic and pulmonic second sounds have the same quality, and by comparing these sounds aortitis will be ruled out.

The systolic murmur which occurs with any degree of dilatation (slight, moderate, or marked) at the aortic area is due to the fact that the blood leaving the left ventricle in systole enters a wider chamber and sets up abnormal vibrations. In other words there is an ejection of the blood column during systole through the normally constricted aortic ring into an abnormally dilated aorta. Leiby, Callaway, and Fleming[4] believe that the systolic murmur of an early aortitis may be due to a roughened intima, a dilated aorta with changes in the sounding structure, or a combination of these.

In the beginning the systolic murmur is soft and is usually not transmitted. Later in the disease the murmur becomes rough and harsh and is transmitted into the vessels of the neck, and down along the left sternal border. Occasionally the murmur may be heard at the apex, and we believe that it is transmitted from the aortic area. According to Sprague,[20] murmurs, in the main, are transmitted best in the direction of the current. This is due to the fact that the eddies are propagated and released in this direction, but more to the fact that the point of impact of the stream upon a solid body must be distal to the obstruction. However, if the murumur is loud enough, it will be transmitted somewhat in all directions by local resonators and direct continuity of solid bodies.

When pulsations are felt in the suprasternal notch, this valuable sign indicates the presence of a dilated and elongated aorta. Stern[21] believes that since the first portion of the aorta is held firmly by the heart, which is anchored by the pericardial sac, and the descending portion is attached to the spine, any lengthening must be accompanied by a bulging upward of the arch. This elevation pushes up the origin of the vessels that arise from the arch and causes them to bend and buckle. This buckling places a portion of the artery (especially the innominate or right carotid) into the suprasternal notch where it can be felt and at times seen. The impulse under these circumstances comes chiefly from the right and may be mistaken for an aneursym of these vessels. If the finger is inserted deeply into the suprasternal notch, the aorta itself can be felt as a horizontal pulsating vessel and a diagnosis of an elongated and dilated aorta is easily made. The dilated aorta may cause pulsation in the second or third right or left intercostal spaces which is often mistaken for an aneurysm.

Increased retromanubrial dullness is valuable as a sign only when the aortitis is far advanced and there is moderate or marked widening of the aorta. According to Leaman,[22] if the aorta is inspected in the cadavar, it will be seen to arch in a direction away from the chest wall. In addition, the vessels at the base of the heart are surrounded by lung tissue. Therefore, it is difficult to indicate the diameters of the aorta with any degree of accuracy by percussion over the anterior chest wall. We believe that other conditions such as a deformed anterior chest wall, a thickened chest wall, and emphysema may interfere with accurate percussion in spite of the size of the aorta.

The question of the association of hypertension with cardiovascular syphilis has been a controversial one. Moore, Danglade, and Reisinger[23] studied 105 patients with uncomplicated aortitis who came to necropsy and found that hypertension was an infrequent accompaniment of this condition. Horine and Weiss[24] studied 666 patients with essential hypertension and a control group of 2,000 non hypertensive patients and concluded that syphilis was practically the same in both groups and that, therefore, it cannot have any etiological bearing on hypertension. We believe that our study was more representative because both the group with cardiovascular syphilis and the control group were cases of proved syphilis. On the other hand, Scherf and Boyd[5] state that about 50 per cent of the cases of aortitis have an increased blood pressure (over 150 mm. Hg) which affects the systolic as well as the

diastolic pressures. Nothing is known about the cause of this hypertension, and they believe that perhaps factors other than an extension of the inflammatory process to the depressor nerve in the aortic wall are responsible. From our studies it is obvious that hypertension is a common finding in syphilitic aortitis and can be used as a diagnostic aid because the very frequent combination of these two conditions makes it obligatory to consider the possibility of aortitis in every hypertensive patient, especially when the hereditary factor in hypertension can be ruled out from the family history.

Another disputable question has been that of the role of hypertension in causing the characteristic aortic second sound. Gager[25] believse that a drum-like or booming quality of the aortic second sound is the result of hypertension. On the other hand, Carter and Baker[16] believe that accentuation of the aortic second sound indicates high pressure levels, whereas a change in quality means structural alteration in the cusps, ring, or vessel. According to Best and Taylor,[26] the second aortic sound results from the vibrations set up in the blood column and arterial wall as the aortic valve is placed under tension following its closure. The intensity of the second aortic sound is increased by an elevation in the systemic pressure. The condition associated with intensification of the second aortic sound is hypertensive disease which raises the aortic pressure. We believe that hypertension can cause a change in the character of the second sound at the aortic area in addition to accentuation, only when advanced aortic sclerosis is associated with it. Therefore, in the age group of 40 years or older one is unable to differentiate aortitis from aortic sclerosis, with or without the presence of hypertension. Hypertension causes accentuation of the second aortic sound; aortitis and aortic sclerosis change the character of the second aortic sound.

Although this paper deals primarily with the physical diagnosis of uncomplicated syphilitic aortitis, we cannot help but make a few observations on the use of fluoroscopy and roentgenography. It is generally agreed that the use of these instrumental methods requires experience and judgment. There has been much discussion in the literature concerning the value of fluoroscopy and teleoroentgenography in detecting early uncomplicated syphilitic aortitis. Kemp and Cochems[27] conclude from their studies of 1,000 unselected syphilitics with those of 600 unselected non syphilitics, that there is no evidence that the diagnosis of uncomplicated syphilitic aortitis can be made by teleoroentgenography alone; fluoroscopy and careful clinical evaluation of symptoms and physical signs are essential. Blitch, Morgan, and Hillstrom[28] were unable to find roentgenographic and fluoroscopic evidence of syphilitic aortitis among 30 patients with syphilis of 12 years' duration. Padget and Moore,[29] in a critical review of the literature on the roentgenographic diagnosis of uncomplicated syphilitic aortitis, state that commonly used teleorentgenographic studies were valueless, that the left anterior oblique position might hold some promise, and that fluoroscopic examination in the hands of a competent observer may have some value. Maynard[15] does not place reliance on teleoroentgenography and measurements of the vascular pedicle alone but on careful clinical, fluoroscopic, and orthodiagraphic studies in addition.

In our cooroborative studies of the physical diagnosis of uncomplicated aortitis by means of fluoroscopy and rotengenography, we did not use any measurements but depended primarily on our experience in evaluating dilatation of the aorta. We considered age, sex, size, body build, and chest deformities in our evaluation, and found that the left anterior oblique view was most valuable for the study of the aorta.

It will be noted from our results that uncomplicated syphilitic aortitis is a truly asymptomatic disease. Opinions differ on this statement. Cole and Usilton[3] include in their criteria for the diagnosis of uncomplicated aortitis a history of circulatory embarrassment, progressive cardiac failure, substernal pain, and paroxysmal dyspnea. Maynard[15] has aptly shown that from his experience these findings are the result of the complications of aortitis. Wilson[3] studied 211 patients with syphilitic aortitis and demonstrated that every case with sypmtoms referable to the heart had one of the complications of cardiovascular syphilis or some coexisting disease. He concluded that uncomplicated syphilitic aortitis was an asypmtomatic disease and that no criteria dependent upon symptoms were reliable in making an early diagnosis.

Most text books and periodicals claim that cardiovascular syphilis is rare among congenital syphilitics. Our results show that 16 per cent of the congenital cases studied presented clinical evidence of aortitis and all but one showed some degree of aortic dilatation by fluoroscopy and roentgenography. Kurtz and Eyster[31] studied a small series of 12 cases of congenital syphilis with special reference to the fluoroscopic findings in the heart and aorta. The

fluoroscopic evidence of aortitis was found in 36.4 per cent of the cases. They based the diagnosis of the presence of aortitis and the degree (slight, moderate, or marked) upon the shape of the ascending aorta—sagging of the ascending aorta to the right with pulsations visible to the right of the sternum, and the denstiy of the descending aorta. Cardiovascular syphilis is rare in infants with congenital syphilis, but in older children and adults who have received inadequate or no treatment there is no reason why this condition should not be recognized more frequently, especially since it has been demonstrated that central nervous system syphilis is just as frequent in congenital syphilis as in the acquired type. Kurtz[32] reports a series of 20 cases with congenital syphilis studied by fluoroscopy and orthodiascopy. There were seven males and 13 females ranging from nine to 47 years of age. Most of these had received no antisyphilitic therapy up to the time of admission. The aorta was dilated slightly in seven cases, moderately in one, and appeared normal in the remaining 12. He makes no mention of the physical findings in the eight cases (40 per cent) of aortitis.

All the congenital syphilitics studied were proved cases, and the criteria for the clinical diagnosis of syphilitic aortitis were the same as in the acquired type. Yampolsky and Powel[33] report a case of proved congenital syphilis in a nine year old child in whom the diagnosis of aortitis of syphilitic origin was made pathologically. McDonald[34] reports 11 cases of syphilitic aortitis occurring in patients up to 30 years of age with congenital syphilis. The diagnosis was made post mortem. These cases were not followed for any period of time before death but were admitted to the hospital with various acute conditions. Some degree of coronary ostial stenosis was present in practically all the cases.

### TREATMENT

No attempt will be made to present an exhaustive treatise on the treatment of cardiovascular syphilis but rather to point out the dangers and discuss the routine of such treatment.

It should be remembered that in treating patients with cardiovascular syphilis there is a greater tendency to react unfavorably to medication, and the reaction is likely to be more severe and dangerous than in a patient who has no cardiovascular involvement.

In outlining a program for the treatment of cardiovascular syphilis, Moore[35] considers the possibility of reactions and plans his treatment with the idea of prevention.

During treatment or immediately thereafter the patient may suddenly show pallor followed by marked tachycardia, cold perspiration, failing pulse, and occasionally death within a few minutes. This reaction is likely to occur when the drug used is old arsphenamine, and it may be due either to the greater toxic effect of the drug or possibly to the greater volume of fluid necessary for its administration. By the use of milder drugs less toxic in nature, and in smaller easily controlled doses, this reaction can to a certain extent be avoided.

The very common mild nausea and vomiting that occur in certain types of patients after treatment present a danger in cardiovascular syphilis and should be prevented. Here also smaller doses of less toxic drugs are of value in preventing any serious damage to the myocardium.

A complication associated with the treatment of cardiovascular syphilis is the so-called therapeutic paradox. Here we have an apparently healthy patient with a well compensated heart suddenly developing congestive heart failure after a course or two of antisyphilitic therapy. This is explained by the too rapid healing of the inflammatory tissue and its replacement by scar tissue, with the inflammatory process subsiding but the patient in a poorer condition than before treatment was started. This reaction can be avoided by giving a preliminary course of bismuth and iodides followed by small doses of mildly acting arsenicals such as neoarsphenamine or mapharsen.

The Herxheimer reaction which may occur a few hours after the first injection of an arsenical, must be borne in mind and carefully avoided. The local edema in the aorta that comes on suddenly may be particularly dangerous if it occurs at the mouth of a coronary artery, where it may lead to immediate death. This reaction can be avoided by starting with a course of bismuth and iodides followed by very minute doses of the arsenicals.

All patients with cardiovascular syphilis should be started with a preparatory course of bismuth[36] and iodides, before any arsenical therapy is attempted. This course should consist of at least 10 to 12 intramuscular injections of bismuth subsalicylate in oil (0.1-0.2 gm.) at weekly intervals followed by a similar course of neoarsphenamine (0.1 gm.) or mapharsen (0.01 gm.) and gradually increasing the dosage. With the exception of cases with uncompli-

cated syphilitic aortitis, the dosage should not exceed 0.3 gm. of neoarsphenamine or 0.03 gm. of mapharsen in any cardiac condition. Old arsphenamine should never be used in the treatment of cardiovascular syphilis.

The course of treatment should be continuous without any rest period, and if there are no reactions or contraindications, it should be continued for at least two years. As a rule the best procedure is to alternate the treatment so that 10 to 12 injections of bismuth are followed by 10 to 12 injections of an arsenical, and repeated until treatment is discontinued. Although the serological reaction may be checked during this period of treatment, this should have no bearing on the length and type of treatment. At the termination of this regime of treatment, if sufficiently improved the patient is given a rest period of six months and asked to return for a cardiovascular check up, and if necessary for a short course of further treatment.

If the patient has developed aortic insufficiency or aneurysm, treatment must be more conservative. Under these circumstances the preliminary bismuth and iodide therapy is started, but the arsenicals must be used with caution and in many instances their use should be avoided. If the administration of arsenicals is attempted, bismarsen 0.1 gm. intramuscularly at weekly intervals may be tried. The treatment here as in uncomplicated aortitis is prolonged, and a minimum period of two years is required before any rest period is permitted. Under no circumstances should a patient with recognized coronary ostial stenosis be treated with an arsenical. If congestive heart failure for any reason occurs, bismuth and arsenic therapy must be stopped.

Finally, it must be remembered that once the inflammatory process has started and progressed to scarring, treatment will have no effect on the terminal result. For this reason if treatment is late, uncomplicated syphilitic aortitis and its complications will be detected while the treatment is in progress. In other words, treatment cannot prevent a pathologic process that has already started and is far advanced, but will stop it at its inception and prevent the occurrence of such a process.

Since the completion of this study, penicillin has been added to the armamentarium of syphilotherapy in all its stages. The Army,[37] based upon recommendations made by the Subcommittee on Venereal Diseases, National Research Council, requires that dosage and technic should be uniform in all cases. The total dosage consists of 2,400,000 units of penicillin injected intramuscularly into the upper outer quadrant of alternate buttocks. Sixty consecutive injections of 40,000 units are given at 3 hour intervals day and night for 7½ days. No additional antisyphilitic therapy should be given during or after the completion of the course of penicillin except in the case of penicillin failures.

With penicillin, Herxheimer reactions occur frequently in cases of primary and secondary syphilis, less commonly in cases of latent syphilis, and rarely in cases that have already received some antisyphilitic therapy. The symptoms of this reaction disappear spontaneously within an average of 24 hours in spite of continued regular administration of penicillin, and do not justify the discontinuance of therapy.

Since penicillin is a new drug in the treatment of cardiovascular syphilis with no reports as yet on large series of cases, the caution of Moore[38] should be kept in mind, and we quote: "As matters stand at present, penicillin is a new and powerful addition to syphilotherapy. How best to use it, alone or in combination with other forms of treatment, is as yet undetermined, but is under organized, nation wide, governmentally sponsored study, from which definitive results may be expected rapidly to emerge."

## CONCLUSIONS

The successful clinical diagnosis of uncomplicated syphilitic aortitis depends upon the alertness and the ability of the clinician to recognize this condition as well as upon the extent and distribution of the pathologic process. That this condition is frequently overlooked can be readily appreciated from the difference between its incidence in pathological and in clinical reports. In our series the incidence of uncomplicated aortitis is 24 per cent (304 cases) whereas in reported pathological studies the average incidence is 70 per cent. According to these figures it means that in 46 per cent of the cases the pathologic process is too minimal to be recognized clinically, or is so distributed that recognition by physical diagnosis is impossible.

The clinician is confronted with the problem of diagnosing uncomplicated aortitis in individuals 40 years of age or younger with a history of syphilis, without any complaints and with a negative serological test; or with a negative history, no complaints, and a negative serological test; or with a

negative history, no complaints, and a positive serological test. It has been generally estimated that about 20 per cent of the cases of syphilis give a negative serological test. It is this group of patients, with or without a history of syphilis, that requires our attention as well as our diagnostic acumen for the recognition of uncomplicated aortitis, because they are usually met too late, at a time when they have already developed the complications of cardiovascular syphilis.

With this problem in mind, we were able to recognize 148 cases of uncomplicated aortitis in the younger age group. In this group the negro race predominated by approximately two to one. The presence of the characteristic second aortic sound in the various areas designated was by itself diagnostic of this condition. We know of no other cardiac disease in young individuals (except premature arteriosclerosis) that can produce this sound. Tachycardia due to hyperthyroidism or other diseases may produce it, but it can be easily recognized and differentiated. We believe that hypertension per se is not a problem in the recognition of the characteristic second sound, because hypertension can only accentuate this sound. A sytsolic murmur is commonly associated with the characteristic second sound. The presence of a systolic murmur alone at the aortic area indicates organic heart disease. Willius[39] has aptly made the following assertion, and we quote: "A systolic murmur that is confined to the aortic area is almost without exception indicative of disease of the aorta or aortic valves, namely, aortic stenosis, aortic sclerosis, or aortitis." If in a young individual rheumatic heart disease or arteriosclerosis can be ruled out, a systolic murmur means syphilitic aortitis with or without the characteristic second aortic sound. The other points mentioned under our criteria for physical diagnosis are corroborative.

We wish to emphasize that a clinical diagnosis of uncomplicated aortitis can and should be made in the presence of a normal sized aorta, if definite and unmistakable physical signs are present.

The presence of the large percentage of the hypertensives among the cases of cardiovascular syphilis was somewhat confusing because we were unable to give a valid reason for this finding. From a statistical standpoint we were not able to prove that it was merely a coincidental finding. We agreed, therefore, with the conclusions of Scherf and Boyd,[5] and considered hypertension a diagnostic aid.

We believe that uncomplicated aortitis is not an infrequent finding in congenital syphilis, and that if larger series are studied carefully, our results will be corroborated.

The life expectancy of patients who receive early and adequate treatment with uncomplicated syphilitic aortitis is a normal lifetime, whereas with patients who show complicated cardiovascular syphilis, it ranges from about one to ten years.

SUMMARY

Of 1,270 cases of proved syphilis studied, 24 per cent were diagnosed clinically as uncomplicated aortitis, nad 30.7 per cent as cardiovascular syphilis as a whole. Of the latter group, 78 per cent were cases of uncomplicated aortitis. The proportion of males to females was approximately two to one, and that of the white to the negro race approximately the same.

The criteria for the physical diagnosis of uncomplicated aortitis are presented and discussed, and are found of value in patients 40 years of age or younger. It is more common in the negro than in the white race in this age group.

The high percentage (47.4 per cent) of hypertension among the cases of cardiovascular syphilis studied is not purely coincidental. No valid reason is advanced for its presence.

Uncomplicated aortitis is more common among congenital syphilitics than has been reported heretofore.

Of 128 cases of cardiovascular syphilis that remembered the chancre, uncomplicated aortitis was diagnosed in 38 cases within 10 years after the primary infection.

Uncomplicated aortitis is a symptomless disease. Hints on physical diagnosis are discussed.

Neurosyphilis was present in 26.6 per cent of the cases of cardiovascular syphilis.

Fluoroscopy and roentgenography are of value in corroborating the clinical diagnosis. Uncomplicated aortitis can be diagnosed clinically in a normal sized aorta.

An outline of treatment is presented.

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# THE RELATION OF FLOURINE TO DENTAL CARIES

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In presenting this paper on fluorine and its relation to the control of dental caries, its present value and future possibilities are best shown by a review of the literature which reveals how the effects of this element on dental caries was brought to light.

Fluorine is classified chemically as a member of the Halogen group, the other members being chlorine, bromine, and iodine.

It will be shown that the earlier investigations were not undertaken with a view of controlling dental caries, but for the cause and possible elimination of defects of dental enamel which were afflicting whole communities in the western part of this country. This condition prior to any investigation and in the early stages was known as Colorado Brown Stain, and shortly after as mottled enamel. After the discovery of the cause, a more comprehensive term was used, "dental fluorosis."

The most common clinical manifestations is the appearance of a brown stain and occasionally there appears gray or chalky white spots of varying sizes and intensity, which are an integral part of the tooth structure. This defect is found chiefly on the upper six anterior teeth. Histologically it was shown to be due to the absence of cementing substance between the enamel rods. In other words, there was faulty formation of the enamel.

The earliest investigations were undertaken in Colorado Springs, Colo., in 1908, by Dr. Frederick S. McKay, under the sponsorship of the newly organized Dental Society. This was a new field of investigation with no preconceived theories to confirm or disprove and few fact to go upon. However, there were a few generally recognizable features.

The one fact *generally recognized was the occurrence of the lesion in children* and young adults. Since Colorado Springs was founded in 1871 this roughly represented the first generation reared in the city. Upon examination of the school children, it was shown only natives, or those children who had become residents in infancy or early childhood were involved. *This was the first differentiating fact established.*

It was soon established that those who had taken up residence in the city at an age when tooth calcification had been completed, were not affected. Since this lesion is continuously produced through successive generation of natives, it is correctly classed as endemic. The communities within 40 or 50 miles were now examined and were found to be endemic with few exceptions, the only conceivable difference between the endemic and immuned communities being, that afflicted ones like Colorado Springs, received their water supply from Pikespeak watershed, whereas, the immuned ones received their water supply from a totally different source, though no difference was noted among their waters as to clarity, taste or odor.

However, during the state-wide examination, attention had been called to a small coal mining town, where domestic water supply was being drawn from the mine. The children of this community were severely afflicted. Water from this source, because of its supposed purity had in previous years been hauled in barrels to a nearby town for human consumption which appeared to account for enamel defects in a town that was otherwise immuned.

In addition to the general survey in Colorado dental examinations were personally conducted by Frederick S. McKay in nine (9) states in this country and in Italy and Holland abroad. There was also obtained extensive data by correspondents in Argentina and South Africa. By the time all this data was assembled, it became established beyond doubt that the dental fluorosis was due to the domestic water supplies; but why the water caused this was still unknown. Among the various communities examined some were outstanding in their dramatic con-

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

firmation of the water hypothesis. One of the classical investigations in this country, was conducted in Britton, a small community in South Dakota, which had its original source of domestic water supply from individual surface or dug wells. In later years, mainly for fire protection the town had installed a water system in which the source was from deep or drilled wells. Following this change the succeeding generation of children have been universally afflicted with mottled enamel, formally whereas that lesion had been unknown.

In the generation of children that overlapped, those teeth that had been calcified prior to the change were normal—those calcified after the change were mottled—often both kinds of teeth in the mouths of the same individual. The fact of the change of the domestic water was indelibly recorded in the teeth.

Oakley, Idaho, was another high water mark in the dental fluorosis investigation and very similar to the one conducted in Britton, South Dakota. They too supplemented their old domestic water supply with deleterious effects and upon obtaining a new source of water this dental lesion was completely eliminated. This investigation was unique in the fact that a present water supply was condemned and a new one secured, primarily upon dental evidence.

The study undertaken of the effects of dental fluorosis on inhabitants of an Indian Reservation in Oklahoma, for the first time the incident of dental caries was recorded in relation to dental fluorosis. It being noted here that though the teeth were badly marred as a result of this defect, the incident of caries was markedly reduced.

The investigations of the dental fluorosis at Bauxite, Arkansas, were similar to those undertaken at Oakley, Idaho, except that the old water supply was changed to a new water supply with a result that dental fluorosis was eliminated, and here for the first time was recorded the fact that since the use of fluorine free water there had been a markedly increase of the incident of caries. Also fluorine by chemical analysis was shown to have been present to quite a high concentration in the water previously used and none in the new water. Also at this period of the investigation, fluorosis was being produced by varying the amounts of fluorine intake of experimental animals thus producing fantastic fluorosis in the teeth of these animals.

Analysis for the fluorine content of water in previously known endemic districts were found to contain fluorine in the quantities of .8 p.p.m. to 18 p.p.m. and generally the "new" water supplies were free.

In 1938 during studies conducted in South Dakota, relative to flourine content of water and its relation to caries, among the data included was dental examination of 236 nine year old children with *a verified continuity of exposure to the domestic water containing fluorine*. It was noted that there was a relative absence of caries in decidious as well as permanent teeth of these children, whether or not their teeth showed macroscopic evidence of mottled enamel.

Also a study conducted in the city of Gallesberg, Ill., parallels very closely the one mentioned above. Some interesting figures are available. The fluorine content of the water was 1.8 p.p.m. just enough to cause a mild fluorine in about one half of the children, whereas there was a very definite reduction in the incident of caries in all.

Where the tendency to escape dental caries depends upon the existence of mottled enamel, the practical worth of fluorine in dental caries control would obviously be of little real use.

Therefore, in view of this, an extensive investigation involving 21 cities in four states was undertaken to determine the maximum tolerance of fluorine without producing mottled enamel and at the same time exhibiting a definite control on the incident of caries.

For our consideration children from the age of 12 to 14 are classed in five groups according to fluoride content of the water supply:

| F.P.P.M | CARIES PER CHILD | % CARIES FREE CHILDREN | NO. CITIES | AND CHILDREN |
|---|---|---|---|---|
| (1) 1.4 | 2.4 | 26% | 3 | 843 |
| (2) 1.0 to 1.4 | 2.9 | 20% | 4 | 1403 |
| (3) 0.5 to .9 | 4.1 | 13% | 3 | 1140 |
| (4) 0.0 to .5 | 7.4 | 2% | 11 | 3867 |
| (5) 0.0 | 10.3 | 0% | 1 | 236 |

In all instances the hardness of the water supply was considered and was shown to have had no relation to the incident of caries.

As a result of these investigations, it is fairly well established that the optimal fluorine content of the common water supply would be .1 p.p.m. It must be borne in mind that the water study and its relation to caries, the fluorine was a natural constituent.

In June 1944, there was undertaken in the cities of Newburgh and Kingston, New York, the latter being the control city, a plan to determine the practicability, and safety of fluorinating a communal

water supply deficient in fluorine, to control dental caries. These two towns were chosen after much study, by the city fathers, medical and dental profession and water supply experts.

These two cities of approximately 30,000 population each, with comparable water supply, population groups, climatic condition, economic status, and common source of food supply made them ideal for this study.

Under very exacting conditions white 95 per cent dense sodium fluoride is fed into the water supply so as to maintain a fluorium concentration at all times .9 p.p.m. to 1 p.p.m. This experiment will be continued for from 10 to 12 years at about $25,000 annual cost. The study will be conducted as follows:

Dental examinations of all school children between the ages of 5 and 12 will be made each year.

Pediatric examinations will be conducted to ascertain effects if any of fluorine on growth and development and to determine conclusively the safety of daily ingestion of 1 p.p.m. of F. in water.

In Newburgh physical examinations will be made at regular intervals on groups of 500 children equally distributed as to sex and from birth to 12 years of age. Up to two years physical examinations will be made every three months, thereafter every six months. The initial physical examination will be accompanied by a complete history, with past history and system review in detail. Special attention will be given to the question of physical and mental development and emotional stability. X-ray studies of the bones and centers of ossification and Laboratory tests including blood and urine analysis will supplement the physical examination.

These carefully conducted physical examinations are not being made with a view of showing any benefits to the general physical well being of the child, but rather to be on guard for any deleterious effects resulting from the consumption of the artificially fluorinated water, thereby endeavoring to prove the safety of its use.

This study in Newburgh is expected to establish beyond doubt the following:

1. The non toxic effects of ingestion of artificially fluorinated water.
2. A definite and effective control of caries.
3. A practical and safe method of artificially florinating the communial water supply.

When these factors have been well established as physiological conditions we may well feel that considerable progress has been made in the control of dental caries as was unknowingly begun in 1908.

In the above noted studies on fluorine in the public water supply and its relation to dental caries control, when its effect on the control of caries was fairly well established, investigations were undertaken to determine if fluorine might not be useful in caries control when employed under other conditions.

Dr. Wallace D. Armstrong of Laboratory of Dental Research, University of Minnesota, worked out some very complicated means of determining the fluorine content of enamel. It was shown that teeth that were comparatively free of caries had a larger content of fluorine in their structure than those not so immuned and that the calcium phosphorus magnesium and carbonate proportions of the two classes had not varied.

Dr. Basil G. Bibby, Dean Tufts College Dental School, has done considerable work upon the topical application of fluoride to the teeth in caries control. A group of 100 children at Brockton, Mass., had one quadrent only of the teeth in each month painted with .1 per cent sol. of sodium fluoride three times in one year, the remaining teeth were used as control area. It was found at the end of the year that the painted teeth had 50 per cent less caries.

Test also undertaken at the Coast Guard Academy, one painting for the year, showed no reduction. The incorporating fluorides in ordinary cleaning mixtures used in giving prophylaxis reduced caries as the result of cleaning 2 to 3 per year.

This part of the study of caries control is in its very early development and much work remains to be done, with regard to various age groups, strength of fluoride solution and manner and frequency of application.

There is great need for this type of caries control due to the fact that about one-third of the people of this country do not have communal water supplies, therefore, would not benefit by the addition of fluorine to the water supply.

To date the best results are obtained by children, who during their period of tooth calcification, consume water with a fluorine concentration of approximately 1 p.p.m. The topical application of fluorine has been demonstrated to be many times more effective in small children and young adults.

With all these encouraging results, the press notwithstanding, there is no overall panacea for the elimination of dental caries. Though the fight goes on.

# MALARIA AND THE RETURNING SERVICEMAN

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Malaria has for many centuries maintained the unenviable reputation as the single most important infectious disease to afflict man. Since millions of American troops campaigned in the endemic zones, a major task of the medical services of the armed forces has been to implement all possible measures of control. Under combat conditions, however, it is seldom feasible to put into practice that which is clearly indicated in theory. Personal measures of prophylaxis are apt to lapse in the face of more obvious and immediate dangers, and the fighting troops must precede malaria control units into enemy territory. It is not a matter of surprise, then, that many thousands contracted malaria overseas, in spite of a most intensive and coordinated program of prevention. The purpose of the present discussion is to draw attention to such phases of the malaria problem as may be of some service, perhaps, to the practicing physician in recognizing and treating the disease in the discharged veterans reverting in ever increasing numbers to his care.

The conventional and firmly established life cycle of the malaria parasites need not detain us long. Painstaking investigations have pieced together the intricate evolution of the asexual stages of the parasite in the human red blood cells, the formation of the male and female gametocytes from which, in the Anopheles mosquito, sexual development proceeds until infective sporozoites migrate to the salivary glands. The classical periodic bouts of chills and fever correlate well with the rupture of red blood cells upon maturation of the merozoites, and the greater hazards of *Plasmodium falciparum* infection are attributed to the peculiar tendency of stages of development of this parasite to take place in visceral capillaries, resulting in intravascular agglutination, thrombi, occlusion, and secondary effects. However, many of the facts of malaria are not explained on the basis of the conventional theory. Thus the sporozoites apparently disappear from the peripheral blood for a time after the infective bite, and early claims that they immediately enter red blood cells have not been confirmed. Again, one wonders where the parasites are between clinical attacks, since so often the most searching examination fails to reveal any in the blood cells. The fact that such agents as quinine and atabrine abruptly terminate a clinical attack, and cause parasites to disappear from the blood stream, only to be followed by relapse, requires further elucidation. Finally, it is of considerable interest that malaria induced by the inoculation of human blood differs from mosquito-transmitted malaria in that the infection is readily terminated by quinine or atabrine, and is not prone to relapse. To explain these facts, more and more authorities have come to accept an exo-erythrocytic phase of development of the plasmodia in man.[1] The sporozoites are, therefore, presumed to enter tissue cells before the invasion of the red blood cells takes place. The tissue forms are the sources from which plasmodia are liberated into the blood stream to initiate a clinical relapse. The failure of quinine or atabrine to eradicate the infection may be interpreted as indicating that the exo-erythrocytic forms are either resistant to these drugs, or otherwise inaccessible, contrary to the susceptibility of the parasites in the blood stream. The difference in sporozoite and trophozoite induced malaria suggests that the sporozoites are the necessary precursors of the tissue forms. The absence of the tissue phase may then explain the success of atabrine and quinine in curing malaria induced by the inoculation of human blood.

This newer concept of an exo-erythrocytic phase also affords an explanation of the failure of suppressive atabrine or quinine procedures to prevent

*Presented at Connecticut Regional Meeting on Medical Problems of Returning Veterans, Newington Veterans Hospital, Newington, Connecticut, 13 September 1945, sponsored by U. S. Veterans Administration and Connecticut State Medical Society.*

infection from becoming established in the host. Clinical manifestations may break through in the course of the administration of the drugs, and are most likely to appear after therapy is discontinued. This again suggests that the tissue forms are not affected by these drugs. However, a most significant result was noted after prolonged suppressive regime: infection with *P. falciparum* might be completely eliminated. It is well known that the malignant malaria is of shorter duration and less prone to relapse than tertian or quartan infection. Whether the tissue phase of falciparum malaria is susceptible to atabrine or quinine, or whether immune processes gain the ascendency more rapidly, is not known. The basic fact remains that, in spite of exposure and infection overseas, falciparum malaria is seldom brought back by the veterans to the States if they had been on any prolonged course of suppressive therapy, or if clinical attacks of this type had been intensively treated.

The virtual elimination of falciparum infection in the veterans relieves the American physician of the burden of handling the most treacherous and deadly type of malaria. All the special problems of diagnosis and emergency treatment will not be inherited by him. However, he must remain alert to this eventuality, especially among civilian personnel, others not subject to military discipline, and anyone returning rapidly from an endemic zone who has not been on prolonged suppressive treatment. The disastrous consequences of a failure to recognize these cases has been strongly emphasized by Most and Meleney.[2]

The discharged veteran, then, will exhibit almost exclusively tertian malaria. The physician may well profit from the experiences of the armed services with this infection in order to learn what he may anticipate, and how to manage these patients to their greater advantage. For instance, it has been observed that the course of the infection in tertian malaria contracted in the South Pacific and in the Mediterranean zones differed, notably in the greater frequency of relapse and persistence of the infection among the Pacific veterans. Again, the physician should not place exclusive reliance upon the recurrence of chills and fever every 48 hours. The bizarre and atypical features of falciparum infection have received wide attention, but far less consideration has been accorded the possible unusual clinical manifestations of tertian infection. It is of interest, therefore, to find that, according to Commander Hyman,[3] vivax malaria may simulate cardiac, pulmonary, abdominal and articular disease. Some cases have even masqueraded as disturbances of the central nervous system, a region usually regarded as a special preserve of *P. falciparum*.

The uncertainties of clinical diagnosis are well recognized by malariologists. Even such accepted findings as splenomegaly and anemia may not be in evidence. Coggeshall,[4] on the basis of a group of over 3,000 marines from the South Pacific, noted, in spite of very frequent relapses, splenomegaly in only 5 per cent, and significant anemia was not observed.

To be sure, the task of clinical diagnosis in the discharged veteran will frequently require little effort, since the patient will himself know the nature of his illness. Careful inquiry into the geographical areas in which the veteran has served should further increase the physician's index of suspicion. However, as the months go by the memory of the war grows dimmer, and as the veterans blend with the general population, the continued awareness of malaria may grow less acute in the mind of the physician and patient alike.

The physician will do well to place chief reliance for the diagnosis of malaria on proper laboratory study. In spite of many efforts to develop other methods, the most useful and conclusive technique remains the examination of the blood smear. Since a stained thick blood smear may be 25-30 times as efficient in demonstrating the parasites as the thin one, it is obviously a laboratory aid which should not be omitted when the thin preparations are negative. In any event, repeated examinations are sometimes required, since parasite densities may be very low.

The cutting off of the supply of quinine during the war is no longer bemoaned. Atabrine has weathered early fears and suspicions to assume a position of equality, and even superiority, in relation to the time-honored remedy. The experience with thousands of patients has indicated that an intensive short course of therapy with atabrine will terminate most acute attacks of tertian malaria. It is recommended that 0.2 gms. be given every 6 hours for 5 doses, followed by 0.1 gms. three times a day after meals for 6 days, for a total of 2.8 gms. in 7 days. The drug is safe, although some patients may show symptoms of gastro-intestinal irritation, rarely neuro-psychiatric complications. Some have ascribed skin disturbances, possibly lichen planus, to its prolonged use, while the pigmentation is not regarded as

of any special consequence. The major limitation to the use of atabrine in tertian or quartan malaria is its inability to achieve biological cure, and relapse rates continue high. While the patient may remain quite well between acute attacks of tertian malaria, he may be very ill and most uncomfortable during the attack. Such symptomatic measures as bed-rest, relief of headache, dehydration, of hyperpyrexia are definitely in order. Since the natural course of tertian malaria may run from 3-5 years, the armed services obviously cannot defer discharge pending termination of the disease. The paramount need of a remedy which will act on the exo-erythrocytic phase of the plasmodia is obvious, and current research may lead one to hope that a solution is not too far away.

From the standpoint of the practicing physician, then, his obligations to the discharged veteran suffering from malaria are clear: prompt diagnosis and effective therapy of the acute attack. There is no need of prolonged hospitalization, and indeed such a policy might lead to needless over-concern on the part of the patient. One may, then, reasonably expect the present crop of malaria acquired overseas to vanish from the local scene within some 3-5 years of the acquisition of the last infection. To be sure, as long as garrisons are maintained in the tropics, a constant trickle of newly acquired cases may be anticipated. Groups not under prolonged suppressive atabrine, as already mentioned, and particularly those returning speedily from endemic zones, will have to be especially watched for possible falciparum infection as well.

The influx of veterans harboring plasmodia has posed a public health problem of some importance. Specifically, fear has been expressed that secondary outbreaks may occur in the United States through the infection of local Anopheles mosquitoes. To illustrate, an automobile mechanic was recently encountered in a small southern town. He had been honorably discharged for malaria and battle injuries contracted in the South Pacific. He was provided with a limited supply of atabrine which was soon exhausted. The patient sought no outside medical aid, turned to a liberal supply of whiskey to carry him through the frequent relapses, and literally sweated out his attacks. Cases of this type are quite apt to serve as means of infection of local Anopheles mosquitoes, and a sharp regional outbreak of malaria might result. Secondary epidemics of this sort have already been reported, and others will no doubt follow.

The major responsibility for checking this possibility rests with public health control, national and local, though the practicing physician may render service to the same end by diagnosing and treating effectively cases of malaria that come to his attention. In the post war emphasis on economic retrenchment, it is vital that important agencies as those concerned with Anopheles mosquito control do not come under the legislative axe. The development of potent insecticides, such as DDT, the careful planning of mosquito control as demanded by local conditions should go far to eliminate the threat of any consequential secondary outbreaks of malaria here. Such other measures, as the maintenance of inspection and fumigation of planes and ships must not be relaxed if new species of Anopheles are to be prevented from entering this country. Only if public health control breaks down may one expect a sharp rise in the native malaria rate, such as occurred in Russia after World War I, and recently in Brazil following the chance introduction of *Anopheles gambiae*.

Diminishing the likelihood of wide epidemic outbreaks in the United States are still other factors. The natural trend of malaria native to this country has been downward,[5] although the infection is still endemic in some 24 states of the Union, chiefly in the south and the southeast. Malaria has all but disappeared from such regions as the Connecticut Valley where it flourished in the 19th century. The reasons for this recession are many. Though several Anopheles species are good transmitters of malaria, many others are not. The basic conditions of temperature and humidity in many parts of this country are not, during long periods of the year, favorable for the optimal development of the parasite and the mosquito alike. Probably as important as any factor is the change from a rural to an urban society, and a change in the local conditions which affords less opportunity for the Anopheles mosquitoes and for man to come into as intimate contact as some 60 or 70 years ago. One may therefore expect that similar factors will operate to limit the extension of strains of plasmodia by newly introduced discharged veterans.

In summary, then, tertian malaria is the principal type which the discharged veteran will have, while practically all falciparum infection will have been eliminated by the time he returns to the United States. However, the physician must remain on the alert for falciparum malaria, especially among personnel coming rapidly from endemic zones, and

who have not been on any prolonged suppressive regime. Adequate methods of diagnosis are at hand, principally the stained thick and thin blood smear. The physician may place reliance upon an intensive short course of atabrine to terminate the acute attack, but the relapse rate remains high, and the disease may continue to run its course over several years. Only a drug acting on the hypothetical exo-erythrocytic forms may be expected to achieve biological cure of tertian or quartan malaria. The maintainance of high standards of malaria control by public health agencies should minimize the threat of any significant secondary outbreaks and such efforts must particularly be redoubled in those zones of the country where native malaria still flourishes.

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## REUNION DINNER

## and

## Semi-Annual Meeting of the House of Delegates

It has been more than a year and a half since the physicians of Connecticut have met together, and on December 13, 1945, the Society will celebrate the end of the war and the return of many of its members from military service at a dinner meeting at the Lawn Club, in New Haven. An outstanding program on peacetime medicine will be presented.

The Semi-Annual Meeting of the House of Delegates will be held in the afternoon preceding the dinner.

Check off the date now—December 13, 1945. Details later.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*



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# EDITORIALS

## Care of Veterans

The Veterans Administration is one of the most closely watched agencies in Washington now-a-days and it is being criticized by many for its past performances. Congress is particularly sensitive to what the veterans and their families have today and, by next year when congressional elections roll around, it will be one of the hottest political issues. The President is a close observer and an understanding one, being himself a combat veteran and for many years genuinely interested in soldiers' problems.

American medicine has a definite stake in the developments of the field of veterans' affairs for a great part of the program for years to come will be the provision of medical care not only to the veterans themeselves, but quite surely to their families, unless all signs fail.

Some of the past troubles in veterans' hospitals have been due to the strong over-all control from Washington, leaving little to the individual institutions and their staffs for personal decisions and initiative. Physicians, particularly, are irked by a great juggling of papers and the tangling and untangling of the red tape that is notorious in the Veterans Administration. It is hoped that General Bradley, the new Administrator, will be successful in his attempt to eliminate and discard great amounts of administrative detail.

It seems odd that in time of war medicine gives its best of personnel, ability, and research to provide the finest medical care for the Army and Navy and then when the fighting is over, the profession loses a great part of its interest in the continued treatment of its fighting men. It is not easy to say why this happened after World War I and there are some signs that it may not reoccur now. In the minds of most people who know the quality of medical care in veterans' hospitals, it can be improved, but that improvement can only come through an administration that is interested in such improvement and

in a medical profession that is willing to acknowledge its responsibilities.

It is good to note that early steps have been taken in Connecticut to bring the physicians and the Veterans Administration close together in a mutual understanding of a problem that belongs to them both. The Advisory Committee from the Society to the Veterans Administration is confronted with an exciting challenge and its opportunity for service is unequalled.

## Progress of the Building Fund

The Trustees of the Building Fund have seen fit to release the names of those who have contributed so generously toward a new home for the State Medical Society as of October 8, 1945. The list of these names arranged by counties will be found in this issue of the JOURNAL. It is a very gratifying showing and heartening to those who know to what extent additional space is needed in which to carry on the manifold functions of the Society. It will be a matter of considerable pride to each member when the necessary building is realized and every physician in the State shall have the satisfaction of knowing that he had a part in it. At this point the total number of contributors represents slightly over one-third of our membership, excluding veterans of the recent war. There is yet time for those who have overlooked the opportunity or merely put it off temporarily.

With this list of donors will be found a grouping of contribution by amounts. This has been done not only to point out the number of large contributions, but to give emphasis to the diversification with an average contribution well up near the one hundred dollar mark. Let no one feel, however, that there is any stipulated amount, rather let every one give to what extent his ability shall permit. The new building is badly needed. Organized medicine has developed a prestige in Connecticut and elsewhere which is the equal of that in any other State. We must continue to go forward.

## The High Cost of Security

With the war over and the New Deal passed into history, Washington is becoming increasingly conscious of the mounting costs of government and there is an unmistakable trend toward lowering federal taxes. In this state of mind the cost of expanding the present compulsory social security system is being viewed as a question of first importance. A year ago such a statement would have required qualification but the Calhoun staff of experts, set up by the House Ways and Means Committee to examine and study proposals, is deeply concerned not only with calculations of the ultimate cost of the present system but with the cost of expanding that system, particularly in the provision of medical care, and with the consequences of imposing what might be an unbearable tax burden on individuals. Interesting public comments have been made on this subject.

*The Insurance Field*, published in Washington, referring to the activities of the Committee's staff of experts says, "Two factors have contributed to postponement . . . The second factor is that so great appears to be the added costs involved that the committee has decided to move slowly and cautiously, and only after its own experts have plumbed the depths and probed the costs of each proposal."

The Washington Bureau of *The Chicago Herald-American* has said, "What to do about peacetime social security proposals is putting gray hairs in the heads of the House Ways and Means Committee." This story goes on to discuss the mounting costs of the present system and the problems arising therefrom. It leaves the impression that the Calhoun Committee will find it difficult enough to solve present problems.

*The United States Review*, Washington, comments, "In making a careful study of the provisions and new proposals of the Wagner-Murray-Dingell bill, Mr. Calhoun and his experts have come to a belief that a joint payroll tax of at least 12 per cent and possibly 14 to 15 per cent, will be required to finance it and that provision may have to be made for substantial subsidies from the Treasury as well."

In sharp contrast to this reaction has been the constant refusal of advocates of expansion to discuss the question of cost and the equally consistent policy of the Social Security Board never to make public cost estimates. The policy of proponents of extension of social security may well be reflected by a statement from the National Resources Planning Board in September, 1942. It is in a pamphlet, "After the War—Toward Security." This says, "We have passed the stage when 'financing the program' need be more than a technical problem. If we measure the physical and intellectual stature of our people and our vast national resources, financial problems need be no hindrance. Their complexity need not stand in our way. We require only the will and the

courage to make full use of our national resources."

Advocates of the expanded system have said almost nothing since that time about the cost. Senator Wagner has, when prodded sufficiently, made some vague admissions, but has always inferred that the matter was relatively unimportant. In April, 1945 Senator Murray stated: "The general criticism that we cannot afford comprehensive social security is economic nonsense."

That the public does not think it is nonsense is evidenced by the increasing emphasis on cost and its effect upon general economy that is consistently discussed in the public press, particularly in editorial comment on the Wagner-Murray-Dingell bill. *Insurance Economic Surveys* that has its eye sharply on government fiscal affairs says, "Apparently the ripples created by these pebbles of thought have spread in ever widening circles and have ruffled the thinking of many leaders on Capitol Hill."

## Emergency Maternity and Infant Care Program

*The following statement has been prepared by the Connecticut State Department of Health.*

The Connecticut State Department of Health through its Bureau of Child Hygiene has been cooperating with the Emergency Maternity and Infant Care program of the Children's Bureau, United States Department of Labor. Through this program, the families of some servicemen (those in the lower four pay grades and, during certain periods, air cadets) have been allowed to make application for maternity care, medical care of sick infants and hospital care as required in these cases.

The physicians who have rendered care to EMIC patients have done so in a patriotic manner and have been glad to lighten the burden of servicemen. In spite of the extra time required to fill out forms and in spite of confusion due to the many changes in regulations, physicians have continued to cooperate in every way possible. Hospitals too, have shown great consideration to the families of servicemen and have made it possible for many patients to have the best hospital facilities that were available. Connecticut is proud of the quality of care that physicians and nurses have rendered and that hospitals have given to EMIC cases. Two years of experience under the EMIC program ended June 25, 1945. At this time physicians in the State had completed care of 5,172 mothers and 391 sick infants. Hospitals in the State had administered 49,333 days of care to these patients.

Connecticut was fortunate in having State funds with which to supplement the Federal funds for EMIC cases. Early in the program, there was no Federal money available for administration. Also State funds have been helpful in those cases that did not meet the requirements of the Federal regulations such as when the hospital or physician had not been informed that the case was eligible for EMIC and, therefore, refused to make financial adjustment according to Federal regulations. Through the foresight of the General Assembly of Connecticut, the wives and infants of servicemen in Connecticut were assured of financial assistance when maternity care or care of sick infants was involved.

As Federal regulations changed, there was a gradual tendency towards decreasing the difficulties which eligible families encountered in securing care.

The administration of a program such as the EMIC program is complicated because of the detail involved and because of the misunderstandings which are liable to arise when a third person steps in between two others who are carrying on a business transaction. The health department was interested in lending its aid in promoting care provided by the EMIC program and appreciated the spirit shown by physicians, hospitals and others. The emergency is nearly over and measures which were appropriate during the war should be continued only if they permit the patient freedom in selection of physician and hospital, and assure a high quality of care. An adequate program may require also an arrangement such as medical insurance benefits to allow more freedom of action and hence assure better medical care in urgent situations.

It is understood that the Federal EMIC program is to continue until six months after the war ends. A new bill, however, has been introduced in Congress, S 1318 in the Senate by Senator Pepper and H.R. 3922 in the House of Representatives by Mrs. Norton, which would provide services to all families similar to those services given under the EMIC program to servicemen's families.

## The New E.M.I.C.

It has become increasingly clear that the worker must be satisfied with his conditions of employment as well as with his wages. S-1318 introduced by Senator Pepper and nine other Senators proposes to continue and to expand the present Emergency

Maternal and Infant Care program to cover all expectant mothers regardless of economic circumstance, and to render many other similar services. Much objection has been voiced to this bill by physicians.

If the program embodied in the Pepper bill is to succeed it must be supported by physicians in peace time, at least as well as the E.M.I.C. program has been supported by them during the war. No one can say whether Connecticut physicians will give this support but the probabilities of success or failure of the program might be forecast if searching inquiry were made of the physicians who have worked under the E.M.I.C. program. Between 700 and 800 Connecticut physicians have had experience with this method of providing medical care. They have been handling enough patients over a sufficient length of time to make their collective judgment most significant as to whether or not this type of program can persist in time of peace when the patriotic appeal is lacking.

In seeking this information answers should be given to the question of quality as well as quantity. For example, would support come only from urban and not from rural physicians or would it come more from specialists than from general practitioners. Physicians who have worked under this program should be given the opportunity of expressing their opinion of it, especially as to whether or not they would continue to accept cases after the war emergency is passed. They are the workers who must be satisfied with the conditions of employment and of wages. No other source of information in Connecticut will be so authoritative when it comes time to testify before the Congressional Committee on the Pepper bill.

It is possible that similar statewide studies may give varying answers. Possibly they will differ depending on the economic level of the region. If in a given state physicians like this program and are inclined to favor its further development, physicians in other states should respect their desires. Conversely, if Connecticut physicians feel that the Pepper bill will put an end to private obstetrics and pediatrics and is not needed in Connecticut, such a program should not be imposed on them.

## "They Finished Their Job — Let's Finish Ours"

With this slogan the last Victory Loan campaign was opened on October 29. It will end December 8 and during that period of time the American public will be asked to buy $11 billion in bonds.

The Treasury is asking for $11 billion in the Victory Loan for:

(1) *Care of the wounded and rehabilitation of veterans.* This job is going to be one of the nation's biggest expenses for years to come. Mustering-out pay, education, loans, and general administration of the G. I. Bill of Rights must be added to care of the wounded.

(2) *Cancellation and termination of war contracts.* Huge sums are still required to pay for war materials which were ordered, produced, and delivered months ago. Where contracts are cancelled, payment must be made to contractors for losses suffered, and as contracts are terminated, companies drop out of the excess profits bracket and our taxes go down, thus decreasing Federal tax receipts.

(3) *Inflation.* While unemployment will rise during the reconversion period, the big bulk of American wage earners will still be earning high wages and will have the most money accumulated that they've had for years. Present figures indicate that the "inflationary gap"—the difference between purchasable goods and services and income—will be about $40 billion this year. In addition, Americans have accumulated about $100 billion in savings since Pearl Harbor.

If this extra money is saved, it can provide a backlog of buying power and a steadying influence for years to come. Conversely, if people should try to spend it now before many consumer goods are available, chaos can result.

(4) *Bringing men home.* It's just as expensive as sending them over, and the process will go on for an indefinite period.

(5) *Maintaining armies of occupation.* Housing, feeding, giving medical care to at least two armies abroad is a costly business which will go on for some time—we don't know how long.

The American people should—and will—lend their money to help pay our debts to the men who fought our war and were hurt doing so. We should buy Victory bonds to help pay for bringing our men home. We today, more than ever before, should buy Victory bonds in our own self-interest.

In the past four years, the American people have shown excellent judgment, by and large, in their attitude toward bond buying. As individuals, as communities, as a whole, they have, through their

bond buying, laid the foundation for a sound and prosperous post war economy.

If this same good judgment is exercised during the critical times immediately ahead, we have nothing to fear.

Today, nearly 90 million Americans own war bonds. Nearly 30 million have been buying bonds regularly out of earnings. These people have learned to save and like it. They have accepted bond buying as a method of attaining such personal goals as owning a home, educating children, starting a business. They like the idea of having an emergency fund for a period of post war uncertainty—a period which is now hard upon us.

This is the last of the war loans. There will be no more. This is the final effort we will be called to make. The quota for individuals is $4 billion—$2 billion for E-bonds alone.

## What Subjects Should the Premedical Student Study?

The medical profession has a proper interest in maintaining high standards of competence in its members and this interest extends to premedical education as well as medical education proper. Not infrequently course elections of premedical students are determined by advice from practicing physicians and often that advice shows a wide variation in opinion. It is often contended that the student who wishes to make a superior record in medical school should concentrate on the national sciences in premedical work, but another viewpoint maintains that the premedical student should take only required courses in medical science and spend other time in such fields as social sciences, humanities, and fine arts.

Another controversy has to do with the number of years that should be spent in premedical education. These and like questions are ably considered in a recent study of the subject by Dean Earl J. McGrath of the University of Buffalo in the September issue of the *Journal of the Association of American Medical Colleges*. Dr. McGrath concludes as follows:

"If, however, the doctor is to continue to occupy a position of importance in American society, quite aside from his services in the prevention and cure of disease, he should have a broad liberal education comparable to that of his college classmates who enter other professions and positions of leadership in the world of business and industry. It would seem desirable, therefore, to persuade premedical students to continue their college careers as far as they are able, and if possible, to the bachelor's degree. It would also seem the part of wisdom to advise them to take full advantage of the whole variety of instruction offered in colleges of arts and sciences in order that the profession may maintain the position of prestige it now occupies among educated persons, and in order that the profession may bring to bear on its own problems the widest variety of intellectual competence and understanding. If medical schools will select students in terms of their general intellectual ability and the breadth of their previous education, they will be choosing the students most likely to succeed in the study of medicine and most likely to make the greatest contribution to the profession of medicine and to the society in which they live."

## Yale Medical Library

The physicians of Connecticut will be interested in the recent report of the Historical Library of the Yale University School of Medicine, for it shows the great progress that is being made at this institution. The Library announces in this report that through the good offices of the Department of State it has now received from Switzerland all papers and inventories relating to the great Klebs collection. This library, which will come to Yale before long, includes 22,355 items. Another part of the report which is of great interest is the statement concerning the objectives and future of the library, which reads:

"The Yale Medical Library as a whole is the most important medical library in the State, and we believe that trusteeship of such a collection involves public responsibility to the medical profession of Connecticut. We believe furthermore that by making the facilities of the Library freely available to the State medical profession we shall be rendering service important to the Yale community in the larger sense, and discharging an obligation which the University owes to the general public of the State. At Dr. Thoms' suggestion a plan has accordingly been laid to bring the Library into wider notice in the future and to encourage Connecticut physicians to take advantage of its facilities. The Historical Library in arranging its various exhibitions has attempted to make them timely so as to serve not only the immediate needs of our stu-

dents but the larger interests of the physicians of the State. Connecticut does not enjoy the advantages of an academy of medicine, and while it may not be appropriate to work toward making the Yale Medical Library into a State Academy, we believe that there is every reason why it should atempt within the restrictions imposed by University authority to discharge that function. In order to increase the sphere of influence of the Library, accounts of our principal exhibits have been published during the past year in the CONNECTICUT STATE MEDICAL JOURNAL, and plans have been laid to create an organization to be known as the Yale Medical Library Associates. Ultimately we hope our staff will be sufficient to render more useful service to the local profession than is at present possible; we anticipate that some at least of the support for the larger development will come from the Associates. All this reflects a growing consciousness in the medical faculty that our responsibility to the profession extends beyond the immediate sphere of our students."

## A Good Selection

The nomination by the President of the United States and confirmation by the Senate of the appointment of Watson B. Miller to be Federal Security Administrator to succeed Paul McNutt must bring satisfaction to the medical profession of the country. Except for the ubiquitous Children's Bureau of the Department of Labor, the federal governmental functions which relate to medicine are administered by the Federal Security Agency and it is important that the Administrator have a point of view that is not antagonistic to sound medical achievement and progress. Some of the candidates proposed for this high office could scarcely qualify under this requirement but from Mr. Miller's background and experience it is believed that medicine and government can go forward together.

Mr. Miller has been Assistant Federal Security Administrator with Mr. McNutt and as such aided in coordinating the functions of the Public Health Service, Social Security Board, Food and Drug Administration, the Freedmen's and St. Elizabeth's Hospitals and Howard University. Prior to entering government service Captain Miller, who is a veteran of World War I, served for eighteen years as National Rehabilitation Director for the American Legion.

## X-ray Anniversary

The year 1945 marks a double anniversary in the history of the x-ray, for one hundred years ago Wilhelm Conrad Roentgen was born in Lennep, Germany, on December 27, and fifty years ago on November 8, 1895, he discovered "a new kind of rays" called x-rays at the Physical Institute of the University of Wurzburg in Bavaria. This latter event will be celebrated on a national basis under the sponsorship of the American College of Radiology during the week of November 5 to 10. The celebration will call public attention to the use of radiology in the diagnosis and treatment of disease and seek to educate the public to the services of the radiologist as a physician who specializes in the medical applications of the x-ray. The celebration is further aimed to emphasize to a public largely only familiar with the use of the x-ray in the detection of broken bones, its useful employment in the detection and treatment of many other conditions, including the importance of its use on a wide scale in the early detection of disease in school children.

## B. Austin Cheney

With the passing of Dr. B. Austin Cheney of New Haven the Connecticut State Medical Society has lost a staunch supporter and a loyal friend. An unfailing attendant at State and County meetings, Dr. Cheney was looked upon as one of the elder statesmen in New Haven County, where his interest in medical affairs was sincere and deep. The important responsibilities in hospital and civic matters which he took upon himself and so ably served, even in his advancing years, will always be remembered by those who were privileged to serve under his efficient and kindly guidance. Whatever success may come to the merger of the Grace and New Haven Hospitals will be due in no small part to Dr. Cheney's clear vision and effective planning. His life was a notable exemplification of the good citizen.

*Doctor---*

## INFORM YOUR PATIENTS !

We doctors favor a federal DEPARTMENT OF HEALTH AND WELFARE, with a Secretary in the President's Cabinet.

The Secretary does not have to be a physician any more than the Secretary of War must be a serviceman. The important factor is that all the health activities of the federal government, except those which are peculiar to the armed forces, should be under the same management, together with the welfare activities with which they are inextricably associated. Such a department would offer a health program to the whole nation, preventing the development of class legislation under the pressure of powerful groups working for their own advantage.

This is not a new idea of organized medicine. For more than seventy-five years the American Medical Association has advocated such a move, and at the moment, its principal features are before Congress in a bill introduced by Representative (Dr.) Arthur L. Miller of Nebraska.

WE DOCTORS WANT A FEDERAL DEPARTMENT OF HEALTH AND WELFARE - - - WITH A CABINET OFFICER - - - FOR THE GOOD OF ALL PATIENTS.

**The best public relations man that medicine ever had was the horse-and-buggy family doctor. As the family counsellor, consoler and friend, he established the finest possible public relations.**

**You are his successor in modern medicine. Your State Officers and Committee Members can only be helpers to you. In your daily contacts with your patients, tell them what organized medicine wants and why.**

# VICTORY FOR BETTER HEARING

THE American Society for the Hard of Hearing with headquarters at 1537 Thirty-fifth Street, Washington, and its chapters throughout the United States observes annually in October a National Hearing Week. This is sponsored by the President, many State Governors, and countless mayors and public-spirited leaders in health, education, and industry. Its purpose is to inform the public of the work during the past quarter century for the conservation of hearing and prevention of deafness in children, and the adult exposed to noisy working conditions.

In October, 1944, an editorial appeared in *The Industrial Medicine* called "Let Him Hear." The article covered hearing injuries in industry and presented frankly and squarely a problem which industry must inevitably handle. Tired ears get no relief when machinery noise is reverberated and intensified within smooth, hard factory walls. Moreover, the longer a man works in such environment, the greater may be his hearing loss. The nature of the loss in large part is irrecoverable because the end-organs are rendered less capable of hearing. The American Society for the Hard of Hearing has been aware of this problem for many years. Its committees on noise in industry and insurance have been urging manufacturers to protect the hearing, as well as the eyes, of their workers. Its members are deeply interested in their particular post war obligation by assisting in the rehabilitation of servicemen whose hearing was injured in battle. They did this after World War I, at which time the need for unified service convinced its founders that a national society was essential to rapid progress in hearing conservation.

### INDUSTRY OWES A DEBT TO THE HARD OF HEARING

"Injuries to Hearing in Industry" is the title of an article by Dr. Warren H. Gardner in *Industrial Medicine*, September, 1944. Dr. Gardner tested the hearing of 296 workers in shipyards, and compared their audiograms with those of 315 high school students. The difference was very marked. There was shown a considerable loss in hearing among the workers, compared with the average hearing of young persons. The loss was greater among those who have worked longer in the yards.

In order to ascertain the extent to which age may have influenced these tests, the hearing of the men was tabulated according to ages. By this method the factor of age was eliminated and only brought out once again that the longer the men worked in the shipyard, the greater became the injury to their hearing.

An important implication in these findings is the possibility of claims for industrial injury. A boiler maker who experienced a severe loss of hearing in the shipyards cannot prove that all of this occurred here, since he had worked at his profession prior to this employment. On the other hand, the compensation authorities cannot prove that he did not acquire the loss in his present job, because his hearing was not tested at the beginning of that employment. Dr. Gardner's conclusion is: "If the industrial leaders, and incidentally the army and navy, had obtained hearing curves of their workers before employment, the task of determining justification for accident compensation would have been easier. Meanwhile, the alarming increase in damaged hearing of employees should result in insistence by both workers and employers that hearing be protected by known practical measures."

### PREJUDICE VANISHING

Prejudice against hearing aids has been slowly dying out as these became more commonly seen in the office or on the street. Sometimes not vanity, but genuine fear, was the factor, that the sight of a hearing aid, works against the acceptance for a job, as indeed it has far too often in the past. USES interviewers and the employers they serve can immeasurably aid the cause of good hearing, by public and widely publicized assurance to job-seekers that they are as willing to accept an otherwise qualified worker wearing a hearing aid, as one wearing glasses. Did they but know it, fifty years ago, eye glasses were as much tabooed by employers.

The high cost of hearing aids, another present deterrent to their common use, will be reduced in proportion to the number worn; so that employers would secure more as well as more efficient workers by advocating the combined use of lip reading and a hearing aid.

### ANALYZE THEIR POSSIBILITIES

A tendency, general among the uninitiated public is to "lump" the hard of hearing in an undifferential

*Reprinted by permission, Monthly Bulletin of the Connecticut State Labor Department, Division of Employment Security*

mass, if not to associate them with the "deaf and dumb," often with unconscious emphasis on the *dumb*. "I guess she's mentally sub-normal because she is hard of hearing," said an employment interviewer recently. "What grade of intelligence shall I use in my lecture?" a speaker asked the program chairman of one of the Society's Chapters. Employment interviewers would do well to guard against such errors. People in general have been careless in their treatment of the hard of hearing.

It is true that there will be some unable to qualify for the more specialized positions. Some will be found whose native abilities have been restricted because of deafness increasing since childhood where educational opportunities to correct this were limited and in some case lacking altogether; others unnerved and overthrown by a sudden onset of deafness—and no one to teach them how to meet and surmount the disaster.

This experience was described by one person as "the first plunge into the water. I was confronted with the choice of swimming or drowning—retaining my grip on society or losing it."

PROGRESS TOWARD ULTIMATE VICTORY

The work of prevention of deafness and conservation now extends into the pre-school field. Spurred on by the efforts of the hard of hearing themselves, the medical profession and electrical engineers made astounding progress in research in deafness prevention or cure and in the invention of constantly improved hearing devices. This progress has been immensely accelerated by the demands of war itself for improved means of communication and by hospital research in behalf of thousands of war-deafened patients. War, also, with its manpower shortage, has brought to industry the surprised but incontestable realization that a "handicap" may be a misnomer for one properly placed in the race for efficient production. The records, while still far from being complete, show that the hard of hearing employees in Connecticut industry during World War II made an enviable record for themselves, not only in regularity of attendance, interest and initiative, but high-quality workmanship.

INDUSTRIAL HEALTH PROGRAMS WORTHWHILE

A recent survey of 2,064 plants employing 1,945,551 workers showed that plants that maintained good medical services showed a reduction of 82 per cent in occupational disease; 44 per cent in accidents; 29 per cent in absenteeism; 28 per cent in compensation; and 27 per cent in labor turnover. It has been established by careful study that physically handicapped persons, properly placed, do not increase accident risk. Employers must be willing to give these persons the right to work, industrial physicians must search for their abilities, record their disabilities and recommend them for proper placement. When this has been accomplished the program of *Victory For Better Hearing* will be achieved.

## Ask Doctors' Aid in Office Shortage

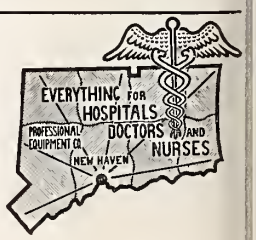
To relieve the present shortage of available office space, practicing physicians are urged to share their offices with doctors who are returning from service.

An editorial appearing in the September 29 issue of *The Journal of the American Medical Association* said: "In large communities, such as cities of over 100,000 population, the problem is apparently far more serious than in the smaller areas. In some larger cities physicians are even remodeling old houses into office space. . . . Many a physician whose office is not fully utilized either in the morning or in the afternoon or even in the evening can make available time and space, as well as the use of his own facilities. . . . The least that can be done for such veterans is to make available to them an opportunity to begin the earning of a livelihood at the earliest possible moment."

## Notice

**The Journal has been asked to establish an exchange with a Spanish publication, Revista De Sanidad E Higiene Publica. If any of our readers wish to receive this publication and contribute extracts of interesting material contained therein communicate with:**
**Managing Editor, Connecticut State Medical Journal**
**54 Church Street, Hartford 3, Conn.**

THOUSANDS HAVE SAID — "Cleverest little device I've seen in thirty years of practice!" Thus, they refer to the $37.50 "Hyfrecator," for the permanent removal of foreign growths by the proven electrodesiccation method. Write or phone for your free twenty-four page booklet "Symposium on Electrodesiccation." No obligation; but we shall offer to sell you one of the "Hyfrecators", of course. Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# THE PRESIDENT'S PAGE

On March 28, 1945, President William Green of the A. F. L., Phillip Murray of the C. I. O., and President Eric Johnston of the Chamber of Commerce of the United States, announced a new charter for labor and management. I quote from the second article of that text:

> "The rights of private property and free choice of action under a system of private, competitive capitalism must continue to be the foundation of our nation's peaceful and prosperous expanding economy. Free competition and free men are the strength of our free society."

With this, the medical profession heartily agrees. We also believe that the free choice of physician is fundamental in our democratic form of government. The sponsors of the Wagner-Murray-Dingell Bill would have labor believe that under that Act, the people would have a free choice of physician. They are not told that the choice must be made from physicians who are willing to participate in this plan.

The Senate sub-committee on Wartime Health and Education has made a study on the proportion of income spent on medical care. Those families with an income of less than one thousand dollars spend six and eight-tenths per cent of that income for medical care. Those with an income of over five thousand dollars spend only two and four-tenths per cent on medical care. The relationship that exists between finances and health may be brought out in these two points:

> Of the ten most important diseases in this country, the death rate is approximately twice as high among poorly-paid, unskilled laborers as among well-paid professional people. The life expectancy of workers in industry is eight years less than those who are not employed in factories and mills.

The answer, therefore, is not in the regimentation of medicine, but in improving the conditions of the working man. The medical profession is intensely interested in this problem, and their position is stated by the American Medical Association in its Constructive Program for Medical Care, as follows: "Sustain production leading to better living conditions with improved housing, nutrition, and sanitation which are fundamental to good health. We support progressive action toward achieving these objectives."

Joseph H. Howard

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

## SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1945 semi-annual meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, in the afternoon of Thursday, December 13.

Joseph H. Howard, President
Creighton Barker, Secretary

### Council Meeting

The Council met for its regular monthly meeting on Friday, October 5. The meeting was called to order at 4:30 P. M. by the Chairman, Dr. Miller. There were present: Drs. Miller, Mullins, Howard, Murdock, Speight, LaMoure, Gibson, Campbell, Moore, Gildersleeve, Thoms, Paine, Weld and Barker. Absent: Dr. Weed.

### Dinner Meeting

It was voted that the semi-annual meeting of the House of Delegates be held in New Haven on Thursday, December 13, 1945. It was also voted that this meeting be followed by a dinner meeting for the Society and the Woman's Auxiliary

### Commission For the Care and Treatment of Inebriates

At the request of the Governor of Connecticut, the Council made nominations of physicians to be appointed to the Commission for the Care and Treatment of Inebriates as authorized by the passage of Sub. H.B. 406 of the 1945 General Assembly.

### Statement of Principles

The report of the Committee on Public Relations presenting a Statement of Principles for the Society was read and approved.

### Pepper Bill

A vote of the Committtee on Public Health of the Society relative to Federal legislation, particularly the Pepper Bill now presented before the Congress of the United States, was approved as follows:

"In Federal legislation pertaining to medical care, the necessity and desirability of Federal aid should be determined not only by a governmental agency, but also by representatives of the medical profession. Supervision of such programs should include competent physicians and the profession of medicine should be adequately represented, in an authoritative advisory committee."

### War History of the Society

The appointment of a committee to compile a history of the participation of the Society in World War II was authorized. Chairman, Lt. Col. James

C. Fox; Colonel Norton Canfield, Colonel Ira V. Hiscock, Ralph Gilman and Colonel Ralph Tovell.

## Committee on Rural Health

It was voted that the Secretary and the Executive Assistant confer with the Secretary of the American Farm Bureau Federation and the Committee on Rural Health from the Federation for the purpose of developing mutual understanding and planning in the field of rural health services.

## Policy For Crippled Children's Clinic

It was voted that Dr. Gildersleeve, Dr. Howard and Dr. Miller represent the Council in a joint conference with the Medical Advisory Committee to the Crippled Children's Program and the State Health Commissioner relative to the discussion now being carried on by the State Department of Health and the Children's Bureau of the U. S. Department of Labor concerning the referral by physicians of persons admitted to services under the State Crippled Children's Program.

## Student Members Elected

John R. Farrell, Long Island College of Medicine, Stamford.

William Stack, New York Medical College, Hartford.

## Questionnaire On EMIC Program

The subject of the continuation and extension of services now given under the EMIC Program as proposed in the Pepper Bill was discussed at length and a proposal was made that the Society engage in a questionnaire among its members concerning their experience with the EMIC Program and their willingness to continue operating under it after the war emergency is over. This proposal was not favored and no action was taken thereon.

## Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Alpert, Max, Bridgeport (A)
Baron, Shirley H., New London (N)
Bidgood, Charles Y., Hartford (N)
Bizzozero, Orpheus J., Waterbury (A)
Bodie, William J., Branford (A)
Calhoun, Hazen A., Higganum (A)
Carey, William C., Meriden (A)
Crane, James E., Stamford (A)
Crosby, Edward H., West Hartford (N)
Coates, Stephen P., Suffield (A)
Dionne, Ulric A., Waterbury (A)
Duffy, Leo T., Hartford (A)
Fox, James C., Jr., Hartford (A)
Harty, John E., Waterbury (N)
Koffler, Arthur, Stamford (A)
Kraszewski, Henry W., New Britain (A)
LaTaif, C. George, New Milford (A)
Lowell, William H., Jr., Hartford (A)
Massey, Daniel, Bridgeport (A)
Montano, Rocco A., Hartford (A)
Roberts, Frederick W., New Haven (N)
Smith, William B., Wethersfield (A)
Sundquist, Alfred B., Manchester (A)
Verstandig, Charles C., New Haven (A)
Walker, Robert, West Hartford (A)
Wentworth, John H., New Haven (A)
Wies, Carl H., New London (A)
Wilson, George C., Wallingford (N)

The Connecticut Medical Examining Board has announced the recommendation of the following physicians for licensure to practice medicine on the endorsement of credentials

| NAME | MEDICAL SCHOOL | CREDENTIAL | RESIDENCE |
|---|---|---|---|
| Robert H. Abrahamson | McGill 1930 | New York | New York City |
| Olive L. Bateman | Minnesota 1940 | Minnesota | New London |
| Florence A. Beaulieu | Tufts 1931 | Massachusetts | Mansfield Depot |
| Edward L. Besser | Johns Hopkins 1937 | N. B. M. E. | Manchester |
| John L. Capalbo | N. Y. Med. College 1941 | N. B. M. E. | New London |
| Daniel S. Cunning | Albany 1914 | New York | New York City |
| Charles T. Flynn, Jr. | Yale 1943 | N. B. M. E. | Hamden |
| Joseph D. Kelly | Georgetown 1912 | New York | Greenwich |
| John R. Lyddy | N. Y. U. 1944 | N. B. M. E. | Bridgeport |
| Benjamin Margulois | St. Louis University 1927 | Massachusetts | Mansfield Depot |
| Clifford W. Mills | Cornell 1938 | New York | Norwalk |
| Frank Palazzo | St. Louis University 1943 | N. B. M. E. | Bridgeport |
| Eloise B. Peterson | University Vermont 1928 | Vermont | Westborough, Mass. |
| Julius D. Stein | Columbia 1944 | N. B. M. E. | Milford |
| John A. Woodworth | Syracuse 1939 | N. B. M. E. | Moosup |

## Meetings Held During October

Monday, October 1, 4:30 P. M.
Board of Trustees of the Building Fund

Thursday, October 4, 4:30 P. M.
Executive Committee, Connecticut Cancer Society

Friday, October 5, 4:30 P. M.
Council of the State Medical Society

Wednesday, October 10, 10:00 A. M.
Oral interviews, the Connecticut Medical Examining Board, Hartford

5:00 P. M.
Committee on Public Relations

Wednesday, October 17, 5:00 P. M.
Committee on Hospitals

Wednesday, October 24, 4:00 P. M.
Executive Committee, Association of Tumor Clinics

7:00 P. M.
Committee on Industrial Health

Wednesday, October 31, 5:00 P. M.
Special Committee to Study Workmen's Compensation Laws

## Meetings Scheduled For November

Thursday, November 1, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, November 2, 4:30 P. M.
Council of the Society

Tuesday, November 13, 10:00 A. M.
Written examinations, the Connecticut Medical Examining Board, Hartford

Wednesday, November 14: 10:00 A. M.
Written examinations, the Connecticut Medical Examining Board

5:00 P. M.
Committee on Public Relations

Tuesday, November 27, 10:00 A. M.
Oral interviews, the Connecticut Medical Examining Board

Wednesday, November 28, 7:00 P. M.
Committee on Industrial Health

Unless otherwise specified, meetings are held at the offices of the Society, 258 Church Street, New Haven.

## Industrial Activity in Connecticut

Several months ago the JOURNAL, with the aid o the State Department of Labor, published a survey of potential post war industry in Connecticut. Nov that the "post war" period is actually here, a mor exact statement of peace time industry in the stat can be made. Conditions are changing continuously but with the aid of the Connecticut Manufacturers Association, the JOURNAL can present a statement o things as they are and further appraisals will b given from time to time in the future.

FAIRFIELD COUNTY

*Bridgeport*—"Brass company plans $5,000,000 expansion. Typewriter and business machine manufacturers will be busy for next four years with heavy increase in employment. One large company is known to have advertised unsuccessfully for 200 workers (male and female) at starting rates of 69¢ to 90¢ upwards, all with incentive pay and 10 per cent night bonus, in addition, without success. Approximately 4,000 job orders reported to be in hand of U.S.E.S."

*Norwalk*—"Manufacturers absorbing shock of reconversion fairly well. About 1,550 layoffs to date. Job openings with U.S.E.S. total 972. Help wanted advertising continues by peace time lines. Local estimates place current employment in industrials as already 11 per cent ahead of 1939 figures."

*Stamford*—"High point in unemployment compensation claims reached. Claims leveling off. Many included in claims now returned to work. Manufacturers report difficulty in getting job takers."

HARTFORD COUNTY

*Bristol*—"Using 100 per cent as basis for year 1940, employment during peak war period was 145 per cent of year 1940. Estimated to be 122 per cent of 1940 figure during immediate post war years."

*Hartford*—"Job deficit expected to be nullified by out-migration, expansion of commercial lines, additional payrolls in reconverted plants, and ordinary withdrawals from labor market. Financial and mercantile activity a stabilizing factor. Difficulty in getting manpower, despite numerous advertising appeals, reported by both manufacturing and non manufacturing business. Member firms of County Manufacturers Association have reported more than 3,000 job openings for listing by the association's employment information service. So far, only some 1,000 job seekers have registered with the associa-

ion. Job opportunities for more than 1,000 women on file. Of people seeking employment who have called at office, 60 per cent have already been referred to employment offices of county plants. Thirty per cent of them were hired on their first application."

*New Britain*—"Reconversion situation not serious. Practically all major hardware companies to hire more people immediately and gradually accelerate employment as materials become available. Other major employers to employ more people than before the war. Service trades seriously undermanned."

LITCHFIELD COUNTY

*Torrington*—"Crucial point of unemployment reached. No more layoffs expected. Probably will be 400 more employed within month. Look forward to a good year. Reconversion will be fast and completed by Christmas. Not many plants involved. Employment estimates higher than a year ago."

*Winsted*—"Surveys indicate shortage of labor, particularly female. Newspapers advertising daily before and after V-J Day. No serious reconversion problem outside of relocation of facilities and production lines."

MIDDLESEX COUNTY

*Middletown*—"Middlesex County had 1,882 unemployment compensation claims as of September 1. According to U.S.E.S. 1,018 job openings listed as of that date. County manufacturers still in need of help. Field in retailing, service trades, utilities and institutions presents brisk demand. Connecticut State Hospital conducting extensive campaign through radio and newspaper. Several new concerns to open in Middletown. Old Cromwell industry to reopen and absorb some hundred people. Middlesex County will be in a position to furnish jobs to any jobless willing to work."

NEW HAVEN COUNTY

*Meriden - Wallingford*—"Meriden - Wallingford future bright. Survey of 43 Meriden plants indicates that by July 1, 1946 14,000 will be employed compared to 14,100 on the payrolls July 1, 1945—an increase over 1939 of approximately 4,500, when 9,500 were employed. Survey in Wallingford indicates 3,800 on payrolls on January 1, 1946 compared to 3,000 July 1, 1945 and 2,600 in 1939. Large plant that employed 100 during war to reach 1,000 before year end. Largest war plant in Meriden announced that within short time, number on payroll will be same as V-J Day. Figures from U.S.E.S. on August 31, 1945 indicate that labor demand for Meriden-Wallingford-Southington area is 892. Only 1,236 permanent lay-offs since V-J Day. Does not include temporary lay-offs, expected to be recalled soon. Silver industries reconverting rapidly. Within short time their employment figures will be in excess of war-time figures."

*New Haven*—"One of New Haven's largest employers, for 10 years prior to war averaged 3,600 employees. Its post war survey estimated 5,000. Now has 5,500 working with prospects of 300 more when one department starts production. By working around the clock, within five days after termination of government contracts all manufacturing tools used on war production removed and half of tools required for peace production reinstalled. By end of August reconversion practically completed. Figures for area not yet available, but above company's experience typical of community."

*Waterbury*—"General opinion that Waterbury fast approaching reasonably balanced civilian production program. Anticipated, through expressed opinions of industrial and commercial leaders, that employment figures will rise. September survey now being made. Brass companies recalling those temporarily laid off. Others reporting employment opportunities. Few plants have real physical reconversion problem. 40,285 employed in August 1945 compared to 32,692 in August 1939."

NEW LONDON COUNTY

*New London*—"Combined efforts of local industry have made reconversion problem relatively simple. One concern obliged to lay off small percentage during 30 day reconversion period. Most of this group will be reinstated. Three industries currently advertising in local papers for help. Shipbuilding industry particularly fortunate in efforts to retain sufficient government contract construction to assure force of approximately 4,700 employees throughout 1946—several hundred per cent above normal peacetime complement. Several manufacturers contemplate additions to regular peactime lines. Hesitancy shown in a few labor classifications in accepting slightly reduced wage scales incidental to peacetime production. One firm unable to employ enough skilled help by offering 15¢ per hour over prevailing wage scales. Increase in non manufacturing employment permanently absorbed with net gain over 1940. Definitely optimistic trend. Housing situation still critical until a large percentage of service personnel are redeployed to other sections of the country."

*Norwich*—"On V-J Day about 700 persons in Norwich area displaced because production on government contracts ordered stopped. Three weeks later approximately 1,200 out of work due to the war's end. A great many of these persons living in the area who had been working in other war producing centers. Yet plants in the area, especially textile, severely undermanned. Volume of daily 'help wanted' advertising in local newspapers almost equal to that prior to the end of the Pacific war. Plants in area can employ more people than war's peak period, assuming help available. Recheck of total industrial employment currently being undertaken. Commercial employment survey also being taken to determine whether gap exists between the number of employables and job opportunities."

TOLLAND COUNTY

*Tolland*—"Plenty of job opportunities. Main difficulty securing takers. Employment service having difficulty referring applicants."

WINDHAM COUNTY

*Willimantic*—"Figures exclude large aircraft engine plant now being negotiated for sale to well established manufacturers by Defense Plant Corporation. 1940 employment figures 2,540. At peak of war period, 3,370 employed. Estimated future employment will be 3,520. New industry should absorb bulk of surplus manpower occasioned by withdrawal of aircraft plant."

## REPORT OF THE CONNECTICUT STATE MEDICAL SOCIETY DRAFTING PANEL TO THE COMMITTEE ON MEDICAL PUBLIC RELATIONS FOR TWENTY-SIX STATES

The Connecticut State Medical Society endorses the 14 point program of the Council on Medical Service and Public Relations of the American Medical Association. We wish to add by way of emphasis and amplification the following statement on matters which seem important to us at this time.

1. A sound health program for the nation calls for a federal department of Health and Welfare with a secretary in the President's cabinet. In this department should be included all of the federal agencies having to do with social security and health including the hospital system of the Veteran's Administration. It should not, however, include those health services peculiar to the establishments of the armed forces.

2. The national health program should be developed on a pattern which recognizes that any given function which is best performed by government should be performed by it and that it should be administered by that branch of government, local-state-federal, which is closest to the problem. Functions which are best performed in the atmosphere of private enterprise should be undertaken by non-governmental agencies. Political interference with medical practice must be avoided.

3. Federal participation in the national health program should be limited to:

a. The performance of such public health functions as are clearly of interstate or national concern.

b. The development of professional and administrative standards.

c. The subsidy of medical education.

d. The subsidy of scientific research.

e. Aid to local and state agencies where such need is established by local or state surveys. In supplying needy areas, political and regional considerations must not lead to the development of expensive public enterprises in areas where the need is minimal. We believe that the distribution of public funds among the states can be made on an equitable basis making grants-in-aid for the development of those services which can be best utilized by this or that state. For example, a state where there is great need for new hospitals may be supplied with hospital facilities, whereas in a state where hospitalization is adequate, the distribution may be made in favor of medical education or scientific research within that state. Such a well considered expenditure of public funds would be facilitated by the establishment of a single department of Health and Welfare as previously suggested.

4. Even though our health conditions and services are equaled by few if any countries in the world, the health consciousness of the United States has been aroused to an extent which calls for and is willing to support a vast development of new hospital and health center facilities. This country is willing no longer to tolerate areas which lack essen-

tial health facilities. The present immediate need is therefore to determine by survey the areas of need and supply them, and second, to develop a well integrated hospital and health center system which will use to the fullest our present and future facilities.

5. We believe that generous aid should be provided for medical education on all levels—undergraduate, intern and resident and postgraduate. Good medical care demands more and ever better physicians. The same can be said for the ancillary services and for dentistry. Special opportunities should be provided for discharged medical officers.

6. We believe that the veteran and his family should be cared for as far as possible with the medical and hospital resources of his own home community. They should be insured by the Veterans Administration in the local plans for prepaid medical and hospital care. Where such plans have not yet been developed or where by reason of long continued illness the benefits of such plans prove inadequate, the Veteran's Administration should pay the additional costs just as reinsurance takes up the more than ordinary risk. We believe that this procedure would be greatly appreciated by the veteran and that it will enable him more speedily to take up his customary place in his community.

7. We believe that federal funds should be provided to supplement the programs of State Departments of Public Welfare wherever the need is clearly shown. Uniform and humane provisions should be fostered in such a manner as to discourage as much as possible needless dependency and to develop to the utmost in the wards of the state the spirit of independence and self respect. Special institutions for the indigents as a class should be seldom necessary if suitable arrangements are made with existing hospitals to care for these people with little or no differentiation from their more fortunate neighbors.

8. We believe that research and education in the field of Industrial Medicine and safety engineering should be encouraged and subsidized where necessary.

9. We believe that the rapid development of voluntary plans for prepayment of the costs of hospital and medical care indicate that the wage earner can be assisted materially to meet his need for essential medical care. The Federal Government should aid and encourage such voluntary plans and should not resort to a costly system of state medicine unless voluntary plans have been found ineffectual.

C. Charles Burlingame, M.D., *Chairman*
Howard S. Colwell, M.D.
C. Frederick Yeager, M.D.
Thomas J. Danaher, M.D.
Mario L. Palmieri, M.D.
George H. Gildersleeve, M.D.
Donald M. Beckwith, M.D.
William M. Shepard, M.D.
Howard W. Haggard, M.D.

## Where Does the CIO Program Lead?

According to Dr. Willford I. King, professor of economics, New York University, the C.I.O. favors installing a system of public medicine. If this is done, it will again mean expanding the field of public activity at the expense of private enterprise. If the system as proposed is adopted, it will siphon into the public treasury most of the income now spent for medical care by the citizens. Past experience indicates when government takes over any function the citizens gradually lose all control of the way that fuction is administered. Presumably, therefore, medical treatment will gradually be regimented to suit the whims of the administrators.

## Dr. Nichols Wins Golf Title

Ralph W. Nichols of New Haven won the playoff for the Connecticut Senior Golf Association Championship in September by defeating George H. Gamble, also of New Haven, by one stroke, at Brooklawn Country Club. Dr. Nichols posted an 81 against Mr. Gamble's 82. The playoff resulted from a tie the previous month at Shuttle Meadow Country Club.

**PROFESSIONAL HEADACHES:** — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.




(SEE PAGE 2)

## Governor Names Commission On Care of Aged and Chronically Ill

Announcement has been made of the appointment by Governor Baldwin of the Commission for the Care and Treatment of the Aged, Infirm and Chronically Ill, which was authorized by the passage of Substitute for House Bill 144 by the 1945 General Assembly. The members of the Commission and their terms of office are as follows:

A. Nowell Creadick, M.D., New Haven. President of the Connecticut Cancer Society—3 years.

Joseph H. Howard, M.D., Bridgeport. President of the Connecticut State Medical Society—2 years.

John W. Lamb, Plainville. Representative, Connecticut Legislature, Chairman of the Committee on Public Welfare and Humane Institutions—2 years.

James L. McConaughy, Cornwall, Chairman, United China Relief, formerly Lieutenant Governor of Connecticut, formerly President of Wesleyan University—3 years.

Frances B. Redick, Newington, formerly Secretary of the State—2 years.

The Commissioner of Health, Stanley H. Osborn, M.D., and the Commissioner of Welfare, Robert J. Smith, are ex-officio members of the Commission.

The selection of the Commission has been awaited with keen interest around the State, particularly among persons in the fields of medical care, public health and social welfare. It has long been recognized that the development of a sound, integrated program for the care of the chronically ill and aged is a serious responsibility of the State and that it constitutes a major problem with wide medical, social and economic implications. The assignment to the solution of this problem of five citizens notably outstanding in their diverse areas of activity and prominent in the life of the State is the first step in the solution of the problem and one that will meet with general approval and support.

The Commission is directed by the new statute to "study the problems of care and treatment of the aged, infirm and chronically ill people of the state, plan, construct or purchase, lease or otherwise acquire and staff and operate such buildings as it deems necessary for the care of such persons. Said commission shall fix rates for care at such institutions and shall determine policies and adopt regulations necessary to carry out the provisions of this act."

The statute empowers the Commission to employ and fix the compensation of a director and such other employees as it may require and makes the usual provision for a biennial report of findings, activities and recommendations to the governor and the general assembly.

The appropriation originally requested for this important undertaking was reduced prior to passage of the bill to $25,000 which is obviously inadequate for the acquisition of land, buildings or other capital equipment. It will, however, enable the Commission to make a thorough and detailed survey of the scope of the problem, the existing facilities and the additional components which are needed, and to bring before the next general assembly wise recommendations for a sound, progressive program for the care of the aged and chronically ill people of this State.

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## Dr. James C. Fox Accepts Position at Hartford Hospital

James C. Fox, at one time commanding officer of the 39th General Hospital located in New Zealand and formerly clinical professor of neurology at Yale University School of Medicine, has entered upon his new duties as assistant medical director of the Hartford Hospital.

Dr. Fox wears the Bronze Star Medal which he was awarded "for meritorious performance of duty in the South Pacific theater." At a farewell party given in New Zealand, his commanding officer said of him: "He has carried the primary responsibility for the medical disposition and evacuation of many thousand of patients. His sound judgment, breadth of vision and complete personal integrity have combined to make him the respected counsellor for each one of us. His complete loyalty to the unit has been a constant inspiration."

When he returned from New Zealand, just a year ago, he was assigned as chief of medical service of the Cushing Hospital in Framingham, Mass.

A graduate of Williams College, 1916, Dr. Fox attended the Medical School of Johns Hopkins University, where he received his M.D. degree. He later interned at the Johns Hopkins Hospital in 1920-21.

Dr. Fox will head several professional departments at the Hartford Hospital.

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|---|---|---|---|---|
| Fairfield | 358 | 120 | 33.5 | $79.7 |
| Hartford | 459 | 151 | 32.9 | 73.8 |
| Litchfield | 63 | 33 | 52.4 | 84.8 |
| Middlesex | 61 | 22 | 36.1 | 58.0 |
| New Haven | 461 | 182 | 39.5 | 85.2 |
| New London | 106 | 38 | 35.8 | 108.8 |
| Tolland | 15 | 5 | 33.3 | 61.0 |
| Windham | 30 | 13 | 43.3 | 83.8 |
| Total | 1553 | 564 | 36.3 | $81.1 |

### Amounts of Contributions

| Amount of subscription | Number of contributions |
|---|---|
| Under $25 | 56 |
| $25—$49 | 100 |
| $50—$99 | 288 |
| $100—$199 | 86 |
| $200—$299 | 11 |
| $300—$499 | 15 |
| $500 and over | 8 |
| | 564 |

## Health Service Organized For Ecuador's Rubber Area

Five dispensaries have been opened in northwest Ecuador for rubber workers, according to reports to the Institute of Inter-American Affairs, Washington.

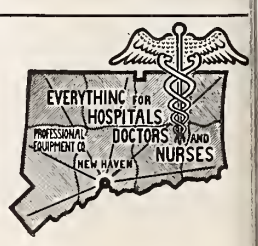
Seventeen dispensaries now are operating in the Ecuadoran rubber area through the cooperation of the Ecuadoran government and the Institute, which is an agency of the Office of the Coordinator of Inter-American Affairs.

Each dispensary is staffed by a physician trained in tropical disease control, usually assisted by a laboratory technician. Dr. Curtis E. Sauer, head of the institute's medical section in the Ecuadoran area, reports that in one month 920 patients were treated in the dispensaries.

The new dispensaries are in Tena, Province of Napo and Pastaza; Concepcion, Province of Esmeraldas; and in Cojimines, Coaqui and Jama, in the Province of Manabi.

"Practicantes" have been stationed at six rubber centers. The practicantes are specialized medical assistants who distribute medicine and administer minor treatment.

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(SEE PAGE 2)

# Reply of the Connecticut Hospital Association to the Recommendation of the Radiological Section of the Connecticut State Medical Society for a Revision of the Present Method of Compensation to Radiologists

The Radiological Section of the Connecticut State Medical Society has asked for a revision of the time honored method of compensation for their services to the general hospitals of the State. They recommend that the single x-ray charge now made to private and semi-private patients in hospitals be separated into a hospital charge for technical service and a professional fee. It is difficult for the Connecticut State Hospital Association to take any action in the premises because it is without authority. Throughout its history the Association has been a deliberative one conducted for the purpose of discussing common problems for mutual benefit. Usually when cooperative action is wise the Association recommends a course of action to its members and leaves them with complete liberty to do as they see fit.

In considering the request the Council of the State Medical Society should first take into consideration the fact that the recommendation is contrary to the Principles of Relationship Between Hospitals, Radiologists, Anesthetists and Pathologists, approved in 1939 by the American Hospital Association and the Radiological Intersociety Committee officially representing the American College of Radiology, the American Roentgen Ray Society, the Radiological Society of North America, and the American Radium Society. These principles were reaffirmed in 1944 by both the A. M. A. and the American Hospital Association and are as follows:

1. The radiological service of the hospital shall be maintained primarily for the benefit of the sick.

2. Every hospital radiological department should be under the direction of a competent radiologist, preferably a diplomate of the American Board of Radiology or one who is working toward that objective. If, because of size or isolation, such arrangement be not feasible, some member of the general medical staff trained in radiology should be in charge and a consultation service arranged with a nearby radiologist.

3. The radiologist is entitled to recognition as a professional member of the medical staff and as head of a hospital department.

4. The preservation of the unity of the hospital and its component departments and activities is an essential administrative principle. This principle can be maintained without any infringement on professional rights or professional dignity.

5. Inasmuch as no one basis of financial arrangement between a hospital and its radiologist would seem to be applicable or suitable in all instances, that basis should be followed which would best meet the local situation. This may be on the basis of salary, commission or privilege rental, but in no instance should either the hospital or the radiologist exploit the other or the patient.

6. When an arrangement is effected whereby the radiologist of the hospital pays a rental for space and service, cares for non pay patients and in return retains all private fees collected, such contract should clearly cover the matter of depreciation of equipment, replacements and additions, should protect the radiologist against excessive non pay work and should take into consideration the "good will" by virtue of which a large proportion of the paying clientele is attracted.

When the principles were adopted in 1939 the report stated that:

"The American Hospital Association and the Radiological Inter-Society Committee view with disapproval the proposal that the actual cost of films and associated overhead be separated from the professional charges of the radiologist or that the responsibility for this department be divorced from the hospital. While in many instances this would be a financial relief to the hospitals, it would probably result in frequent omission of the radiological consultation with a specialist in radiology, would mean less efficient radiological service with potential legal complications and would tend to create difficulties with national and other organizations requiring supervision of the radiological work by a competent radiologist."

The Connecticut Hospital Association sees no reason at this time for departing from these established principles, nor for considering four new principles at variance with those accepted on a national basis. In support of this position it makes the following comments and observations:

1. The Radiological Section of the Connecticut State Medical Society bases the suggestion that "the present single x-ray charge now made to private and semi-private patients in hospitals should be separated into a hospital charge for technical service and a professional fee" on a recent affirmation of the Connecticut State Medical Society that "the inclusion of professional medical fees in Hospital Service Insurance contracts is unsound and detrimental to the best interests of medical practice." The Connecticut Hospital Association takes no exception to this statement, but would like to point out that the exact meaning of words and phrases is important in this connection. Certainly the direct fees of physicians and surgeons should not be included in Hospital Service Insurance contracts, but this does not mean that subscribers to Blue Cross or Hospital Service organizations should be deprived of any service customarily available to private hospital patients. The prepayment of hospital bills through such means does not primarily affect medical practice or the relationship of patients to their private physicians. In a discussion concerning this subject at the House of Delegates of the A.H.A. the statement was made that "the extension of prepayment plans for medical and hospital care must not be interrupted by any group which would use the acknowledged values of such prepayment services to the public as a device to force a set . . . pattern in the relationships between physicians and hospitals."

The Hospital Association is unable to reconcile the acceptance by the radiologists of charges by hospitals for x-ray services to insurance companies under the compensation law while they object to such charges under Blue Cross hospitalization insurance. There is no essential difference in the principle involved. The inclusion of x-ray services in bills to commercial insurance companies practically puts the stamp of approval on such charges to non profit insurance companies.

2. The Radiological Section has requested that the Council approve four principles and that they be adopted by Connecticut hospitals as a guide in their relations with radiologists. The following comments appear to be pertinent:

*Principle One: "That the practice of radiology is a part of the practice of medicine and in hospital practice the radiologist should have the same status as chiefs of other services."*

The practice of radiology is obviously part of the practice of medicine, and in accordance with the "Principles of Relationship Between Hospitals and Radiologists" the Hospital Association agrees that the radiologist should be recognized, as a professional member of the medical staff and as head of a hospital department. This matter is primarily one for decision by the staffs of individual hospitals. The radiologist cannot always be given exactly the same status as chiefs of other services. In many of the Connecticut hospitals the radiologist is the only physician in the x-ray department. There is no elsewhere in the hospital, except in limited areas of medicine, such a narrow consolidation of a specialty as occurs in connection with radiology. Other chiefs of services do not engage technicians, and perform single handed all the professional services in a department of medicine as do radiologists. For instance the chief surgeon of a hospital does not endeavor to do all the surgery within the hospital or to monopolize all medical work of a certain nature as does the radiologist. The chiefs of services in a hospital usually act as heads of a group of doctors organized for mutual cooperation, consultation and cohesion for the benefit of patients, the hospital and the medical group, all in accordance with approved medical ethics.

*Principle Two: "It is desirable that the professional fee be separated from the charges for hospital service."*

This goes to the heart of the matter under discussion, and is covered by the preceding statement of the Hospital Association's position.

The Association sees no definite advantage to be derived from this proposal.

There should be general recognition of the fact that radiological charges embrace professional services and the Connecticut Hospital Association is of the opinion that this fact is fairly well known.

*Principle Three: "That hospitals should make a charge for technical radiological service based upon actual expenses plus a reasonable return on invested capital and for overhead and replacement, but that the Radiological Department should not be looked upon as a source of extraordinary profit to the hospital."*

The suggestion of the radiologists ignores two fundamental points, as follows:

a. The practice of radiology in hospitals is the result of approximately forty years of development during which time the hospitals as a matter of necessity made the capital investment and took the risk of what was in the early days a new field of endeavor

subject to all the uncertainty of medical practice.

b. The concentration of x-ray services at hospitals is the result of community cooperation. Without it the hospital radiologist could not have the opportunity of doing the amount of business which now comes to him without any particular effort on his part.

Apparently the radiologists feel that in some hospitals at least their services have been exploited. If so, that is a local situation calling for local action. The Association is opposed to exploitation of any kind. If the radiologist is adequately compensated for his services there is no exploitation. This point is well covered by the fifth principle of relationship between radiologists and hospitals.

The Association desires to record its approval of any possible reduction in x-ray charges, and agrees that "the Radiological Department should not be looked upon as a source of extraordinary profit to the hospital." In the past in more than one instance one or more of our Connecticut hospitals has desired to reduce x-ray charges but has been prevented from doing so by radiologists.

The national axiom that "the preservation of the unity of the hospital and its component departments and activities is an essential administrative principle" has some bearing here. Hospitals are non profit organizations. If x-ray charges are to be reduced, other charges to patients must be correspondingly increased, unless the radiologists are willing to bear the principal burden of such reductions.

*Principle Four: "That control of professional radiological fees should be the jurisdiction of the radiologist and that a separate charge for radiotherapy, consultation, interpretation of films, and supervision of technical service should be billed and collected from the patient."*

The radiologists are quite right in requesting that the control of professional fees should be the jurisdiction of the radiologists provided that by "professional fees" is meant *the payment to the radiologist* for his professional services. Certainly he should be reasonably free to place his own valuation upon his services, just as are other members of the medical profession. However, the cost of such professional service is merely one element of the cost of hospital radiological services.

The latter part of this suggested principle appears to be illogical wherein the statement is made that "a separate charge for radiotherapy, consultation, interpretation of films, and supervision of technical service should be billed and collected from the patient." Radiotherapy, consultation and interpretation are professional services, while supervision of technical service is an administrative service.

3. The Radiological Section suggests that seven benefits might accrue if their suggestion were adopted, but the Association is not convinced that such results would flow from the desired procedure. The following brief comments appear to be sound:

a. *Preserving the private practice of radiology in the hospital:* A change in the manner of rendering bills would not effect such a result. In fact bookkeeping mechanics have very little to do with the practice of medicine.

b. *Placing the control of charges in the hands of radiologists:* Consideration can be given, and now is being given, very satisfactorily to individual circumstances under the present practice. No change on this score is indicated.

c. *Preventing the hospital and radiologist from exploiting one another:* No one in this group desires to see any such exploitation nor can such action be approved for a moment. If it has taken place further evidence should be presented for consideration and careful thought should be given to a stronger means of preventing it than the one suggested by the radiologists.

d. *Tending to reduce the cost of x-ray examinations:* We are all in favor of a reduction in charges but again further evidence should be presented to the effect that the proposed move would have that result before approval should be given at the present moment. The Connecticut Hospital Association fears that the recommendation of the radiologists will tend to increase the cost of x-ray examinations rather than to reduce it.

e. *Making the patient aware that personal services of a specialist are being employed:* As previously stated, there is good ground for believing that the public understands that radiological charges embrace professional services of physicians in interpreting the films.

f. *Giving a clear understanding of how charges are computed, and if charges are excessive, where that excess originates:* Until convincing evidence has been presented that hospital radiological charges are excessive, comment concerning this point may be deferred.

g. *Placing the private practice of radiology in the hospital on a similar basis to that of other physicians:* The practice of radiology in hospitals cannot be

placed on a basis similar to that of the practice of other physicians because the conditions are fundamentally different. Other physicians practice medicine in the hospital without the use of very expensive equipment requiring a large amount of space, the employment of technicians and the establishment of an important department of the hospital. Much could be said to emphasize this point. In effect the Radiologists, if they truly desire to place the practice of radiology in the hospital on a private basis would have to set aside and undo the practice of the last forty years. Much stronger reasons than the ones advanced by the radiologists should be presented before consideration is given to such a radical step.

FOUR IMPORTANT OBSERVATIONS

1. It is not clear from the memorandum presented by the "Committee On Hospital-Radiologists Relations" whether a statewide fee schedule by hospital radiologists is contemplated, or whether it is intended that each hospital should divide its charges between technical services and professional fees as may be deemed best. The Hospital Association would like to point out that a statewide fee schedule would operate unfairly in many instances. It is obvious that a fee schedule suitable for a hospital doing a small amount of x-ray business would be unsuitable for a large hospital.

2. If the position of the radiologists is carried to its logical conclusion, they should, as they suggest in the last paragraph, "bill and collect from the patient" for their professional services. The consequences will be grave not only to hospitals but to the radiologists. Should the radiologists establish their own separate schedule of fees for professional services, hospitals will have no interest in the collection of such fees, and the radiologists will have to assume that burden. The collection loss or expense would be large.

3. The Association feels that regardless of all else, the point should be emphasized that such a change as the radiologists have in mind cannot be made on a statewide basis, but is a matter for consideration by the individual hospitals.

4. The Association wishes to record its approval of the basic principle that radiologists should be adequately compensated as medical specialists, somewhat in line with the professional income of their colleagues in the various localities. This is an individual and local problem.

SUMMARY AND CONCLUSION

1. The request of the radiologists is contrary to principles approved by the leading bodies of American medicine, including the American Medical Association and the leading Radiological Societies. The Hospital Association knows of no reason why these principles should not be upheld in Connecticut and respectfully requests the State Medical Society to officially adhere to them. These principles have been ratified by the American Hospital Association and the New England Hospital Association, of which the Connecticut Hospital Association is a subsidiary or affiliated member, in honor bound to maintain the ethical and administrative principles of the parent organization.

2. The radical change contemplated is not justified and will not produce the advantages or results listed. The Association sees no real benefit to be derived, but on the contrary fears some disadvantages.

3. If the four principles in question are to be approved by the Council of the Connecticut State Medical Society they should receive very careful consideration and should be most strongly supported by sound evidence and logic which obviously should be more convincing than the Hospital Association's position, if that be possible.

4. The Connecticut Hospital Association is of the opinion that the proposed step would be detrimental to the fundamental interests of both hospitals and radiologists.

5. Such a change as the radiologists have in mind cannot be made on a statewide basis.

6. The Connecticut Hospital Association in convention assembled, recommended to its institutional membership the adoption of the foregoing principles.

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is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE WAR

## Lieutenant Colonel John A. DePasquale Wins Decoration

Lt. Col. John A. DePasquale, former Hartford physician, has received the Silver Oak Leaf at Camp Gordon, Johnston, Fla.

While a student in 1933 at the Universtiy of Pennsylvania Medical School, he was a private in the 118th Medical Regiment of the 43rd Infantry Division. He received his commission as first lieutenant in the reserve following his graduation with a degree of medicine in 1936. When the 43rd left for the Pacific, he remained with the 118th as executive officer.

He later served on Guadalcanal, the Russell Islands, Rendova and New George. At Rendova he performed operations out in the open, days before the first tents could be put up.

In August, 1943, he returned to this country and was hospitalized for malaria until January, 1944. He reported for duty at Camp Gordon Johnston following his discharge from the hospital.

## Colonel Sadusk Awarded Medal

Colonel Joseph F. Sadusk, AUS, of New Haven has been awarded the American Typhus Commission Medal, according to a recent announcement from the War Department.

## Lieutenant Colonel Bizzozero Decorated by the Pope

Lieutenant Colonel O. J. Bizzozero, on terminal leave of absence after which he will be released from active duty, was informed in a telegram from the Vatican that he has been decorated with the Military Order of St. Gregory by Pope XII. Dr. Bizzozero's lifelong friend, Colonel Charles Poletti, military government commissioner in Lombardy, was given the rank of commander in the same order in a 40-minute audience with the Pontiff.

Dr. Bizzozero returned to Waterbury August 22 after nearly twenty-seven months in North Africa, Sicily and Italy. He had served as chief of the Public Health Section of the Allied Military Government at Palermo, Naples, Rome and Milan. He has been in the Army since September 1942.

## Surgeon General Urges Prompt Release of Eligible Personnel

Major General Norman T. Kirk, The Surgeon General of the Army, expressed the desire that all commanding officers give the fullest possible co-operation towards effecting the early release of Medical Department personnel who are eligible for separation from the service under the announced policy.

At the same time he urged that all medical department personnel occupying key positions and who are eligible for separation under the present criteria volunteer to continue on active duty to assist in maintaining the present high standards of medical care if no replacement is immediately available. It is contemplated that a period of six months' duty will be sufficient time to allow for the arrival of a replacement or for training an officer to take over duties of key positions and thus allow all officers eligible for release to be returned to civilian life.

General Kirk requested that commanding officers make every effort to obtain replacements for medical department personnel eligible for release in order that those officers might be returned to civil life at the earliest possible moment.

Under the announced medical department demobilization policy, Medical and Dental Corps officers are eligible for release providing they meet any one of the following criteria:

a. Adjusted service score of 80 or above.

b. Forty-eight years of age to the nearest birthday or above.

c. Entry on active duty prior to Pearl Harbor excepting critical specialists qualified in eye, ear, nose and throat, plastic surgery, orthopedic surgery, neuropsychiatry or laboratory clinicians. Officers qualified in these specialties are eligible for release if they entered on active duty prior to 1 January 1941 or if they meet the criteria on points or age.

This revised policy on separation is expected to return 13,000 physicians, 3,500 dentists, 25,000 nurses

and a large number of other medical department officers to civilian life by the first of the year.

It will be necessary to retain a large number of low score men in the service for replacement for overseas men having high ASR scores. Other low score men must of necessity be retained in the service to carry on the necessary activities of the medical department in this country and in theaters where American troops are operating.

It is intended that no one eligible for release will be held in the Army because there are men with higher scores overseas who have not been returned home. Eligible men will be discharged as rapidly as they can be processed for separation.

No enlisted personnel with a sufficient number of critical points will be kept because of "military necessity" except those very few men classified in one of three essential technical skills. These are: orthopedic mechanics, electroencephalographers who operate electrocardiac equipment and radio transmitter attendants. The latter is not in the medical department.

## Policy On Overseas Assignment

Only Army physicians who have not yet been overseas will be given assignments in foreign theaters under the Medical Department policy, Major General Norman T. Kirk, Surgeon General of the Army has announced.

The same plan will be followed with reference to dentists, nurses, and other officers of the Medical Department, General Kirk said.

There will also be an age limit for any officer who is to be given an overseas assignment, ranging from 40 years as the maximum for physicians and dentists down to 30 years for nurses, dietitians and physical therapists.

Any officer who is sent abroad for duty in the Medical Department must be under the age shown in the table and must have a point score below that listed in the following:

| CORPS | ASR | AGE |
|---|---|---|
| MC | 45 | 40 |
| DC | 45 | 40 |
| SnC | 45 | 35 |
| VC | 30 | 35 |
| MAC | 30 | 35 |
| ANC | 12 | 30 |
| MDD, PT | 18 | 30 |

This revised policy on overseas assignments is part of the new separation program just announced by which more than 13,000 physicinas, 25,000 nurses and 3,500 dentists will be released from military service by the end of the year.

## Professional Training Planned for Army Doctors

In order to provide qualified doctors for the peace time, Army plans have been formulated to interest Medical Corps officers who are serving for the duration of the war to apply for commission in the Regular Army, Major General Norman T. Kirk, Surgeon General of the Army, announced recently.

Among the more important attractions which will be offered Medical Corps officers who remain in the Army are the following:

1. The Regular Army Medical Corps officer will be assured a professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords.

2. The training and the assignments of Army doctors will be arranged to aid the Army doctors in obtaining board certification for specialties from the recognized civilian specialty boards.

3. Graduate training will be continued with the establishment of Army fellowships, residencies and special courses.

In addition to the above attractions, which carry decided weight with any professional man, the Army affords security in its pension system, hospitalization care and other considerations not usually available in civilian practice, General Kirk said.

Civilian practice on the whole involves considerable uncertainty, and the locality in which a man has established himself and other factors seriously limit the scope of the practice a doctor can engage in, General Kirk said.

This program which is being inaugurated is designed to obtain and utilize to the best advantages the professional skill now available in the Army, according to Colonel Floyd L. Wergeland, director of the training Division of The Surgeon General's Office, and chairman of the committee handling the professional training of Army doctors.

The plans under this policy call for the establishment of graduate training programs at Army installations where the residencies will meet the requirements of specialty boards and arrangements will be made for accrediting by the appropriate specialty boards, Colonel Wergeland said. Another

phase of the program includes the establishment of Army internships at selected Army general hospitals.

Plans outline a procedure for giving professional rehabilitation and specialized training to Regular Army Medical Corps officers who have been in administrative work during the war. These doctors who have not been able to engage in practice because of administrative responsibilities will serve as understudies with doctors who have been active in professional practice. This assignment will lead to continued professional service and eventually specialty board certification.

Medical Corps officers in the Regular Army will be kept in professional capacities without material interruption under this plan.

The advantages of a professional career in the Army will also be brought to the attention of medical students to interest them in an Army commission. Only those who stand scholastically in the upper third of their classes will be prevailed upon to consider the Army for a career.

Reserve or AUS officers now on active duty who desire consideration for commission in the Regular Army may forward through channels Statement of Interest to War Department Adjutant General's Office in accordance with the provisions of War Department Circular 243.

Civilian physicians and former Organized Reserve Corps and AUS officers now on inactive duty status may submit Statement of Interest direct to the Adjutant General's Office.

Future announcements as to securing commission in Regular Army Medical Department will be publicized in current professional and military publications.

## Training Plan On Pacific Diseases

An overall plan for training all personnel on appropriate aspects of prevention, control, diagnosis and treatment of diseases common to the Pacific area has been approved, Major General George F. Lull, deputy surgeon general, announced.

The following training has been planned by The Surgeon General for personnel of medical units being redeployed:

The time allotted to tropical and preventive medicine problems in the basic officers course at Carlisle has been increased and specially qualified instructors have been assigned to carry out this phase of the program.

The present eight-weeks course in tropical medicine given at the Army Medical Center will be reduced to four weeks beginning probably in September and will deal only with diseases common to the Pacific area.

It is planned that a two-weeks course of instruction in diseases of the Pacific area will be conducted at Medical Field Service School, Carlisle Barracks, Pennsylvania, to begin on or about 13 August 1945 for unit surgeons, medical inspectors, chiefs of medical services, and other selected officers from units of the three major forces being redeployed. Instruction will include the prevention, control, treatment, and diagnosis of malaria, dengue, filariasis, Japanese B.—encephalitis, kalaazar, scrub typhus, louse and flea-borne typhus, relapsing fever, plague, bacillary dysentery, amebiasis, schistosomiasis, cholera, salmonella infections, bacterial food poisoning, venereal diseases, trenchfoot, nutritional deficiencies, dermatological conditions and other miscellaneous disease problems to be encountered in the Pacific area. It is planned to assign a group of highly specialized, well qualified instructors to the Medical Field Service School, Carlisle Barracks, Pennsylvania, to handle the instruction in the two weeks course.

Upon completion of this course of instruction, officers will be expected to conduct training programs in the appropriate aspects of the prevention, control, treatment, and diagnosis of these diseases for all personnel present in their units during redeployment. A training guide is being prepared for use in this unit personnel training.

In addition, a supplementary program of instruction for nurses of units being redeployed will be conducted at the training centers to cover the nursing problems associated with the diseases to be encountered in the Pacific area.

## Total Streptomycin Production Only Fourteen Ounces a Month

The War Department stated recently that streptomycin, the new wonder sister drug to penicillin, was being used in thirty Army general hospitals over the country, but that it was so difficult to obtain that the total output of the four companies now making it has been only fourteen ounces a month.

Major General Norman T. Kirk, Surgeon General of the Army, said the Army was receiving many

requests for the drug for use in treatment of urinary and other infections caused by gram-negative bacteria which do not respond to penicillin, but that these cannot be met since the Army neither controls the supply nor can get enough for its own needs in treatment of battle wounded soldiers.

General Kirk said that the four companies, Merck, Upjohn, Abbott and Squibb were the principal manufacturers of the new product, but that other concerns were working at experimental production at pilot plants and that any civilian request for streptomycin naturally would go to these companies.

"The Army and Navy are purchasing only a part of available production," General Kirk said. "In August, twenty-eight ounces—or 800,000,000 units—were purchased. Joint Army-Navy expectations for September are 162 ounces, but it is anticipated that production will be not more than 70 ounces. It is hoped that Army-Navy procurement can be doubled in October—for military needs alone now are about 2,000 ounces a month."

A gram, or 1,000,000 units is the standard daily dose administered in three injections over a twenty-four hour period.

Production is limited severely because the drug is obtained from a natural fungus found in the soil and must be grown under carefully controlled laboratory conditions which cannot be hurried.

The phenomenal production of penicillin which brought it from a laboratory curiosity to a commonly used drug and the price from astronomical figures to about a dollar a dose was due in part to pressure of wartime needs, the General pointed out.

"But," he added, "with the war ended and priorities a thing of the past, streptomycin does not have these advantages, thus working to some extent to hamper production, although industry is doing what it can do to supply the demand."

General Kirk explained that the Army's principal needs are for treatment of soldiers with severed spinal cords who develop urinary tract infections because of a loss of bladder function, and to some extent in treating some cases of meningitis and other infections which do not respond readily to penicillin therapy.

## New Delousing Sets for Overseas Use

More than 400 compact power-driven delousing sets, weighing only 180 pounds, but capable of dusting 600 persons an hour with DDT powder, have been put in operation overseas, according to a recent announcement by the Office of The Surgeon General.

The disruption of sanitary facilities in battle areas has promoted rapid breeding of disease-bearing vermin to such an extent that the situation requires prompt action to avoid epidemics.

Each individual to be treated must be dusted up the sleeves, down the neck, and inside the waist band with approximately one and one half ounces of DDT powder. This is a slow process with a hand duster, but the new delousing outfit, having ten hoses and nozzles, permits the rapid handling of ten persons at a time and is proving invaluable in holding disease in check in infested areas.

The delousing outfit was developed by the Quartermaster Corps in collaboration with the Office of The Surgeon General and the United States of America Typhus Commission.

## New Skin Disease — Atypical Lichen Planus — Announced

Studies of the occurrence of a new skin disease, which has been named atypical lichen planus and is known to the soldier as one of the varieties of "jungle rot," were recently announced by the Office of The Surgeon General.

Following the first Pacific island invasions, it became necessary to evacuate a growing percentage of men from battle areas because of skin diseases which are common in the tropics. Soon after the beginning of the Buna campaign in early 1943, a number of patients with a similar skin disease which was unfamiliar was noted. Further observation made it evident that a new disease was being encountered.

The first Army reports containing descriptions of this new disease, which came to be called atypical lichen planus, were submitted by two Army dermatologists in the Southwest Pacific—Major Thomas Nisbet of Pasadena, California, and Lt. Colonel Charles Schmitt of Pittsburgh, Pennsylvania. Major Nisbet and Colonel Schmitt believed that atabrine, the drug which proved of such exceptional aid in reducing malarial attacks, was probably the underlying cause of the disease.

Army physicians emphasize that the possible relationship of atabrine to atypical lichen planus does not reflect upon the usefulness of atabrine for the treatment of malaria. The skin disease has appeared only in about two or three per thousand of those in the Southwest Pacific who took atabrine regularly

for some months. Atypical lichen planus apparently arises partly because of an unusual sensitivity to atabrine. Physicians are well acquainted with the fact that occasional individuals are sensitive to certain drugs such as quinine, the sulfa drugs, and even aspirin.

Although medical officers believe that atabrine is an underlying cause of the disease, they recognize that many other factors besides atabrine are probably contributory. These include skin injuries and irritations of many kinds, excessive exposure to sunlight, profuse perspiration, dietary deficiencies, and emotional and nervous factors. Older men have been found to be more susceptible than younger men, and the disease occurs among the nurses and WACs as well as among the men.

Medical officers soon learned to recognize atypical lichen planus in its early stages and are able to prevent it from spreading to other parts of the body. In all but a small percentage of cases the disease has cleared up under treatment. To relieve the public and the families of patients of unnecessary worry, Army physicians emphasize that atypical lichen planus is not contagious.

Atypical lichen planus gets its name from its resemblance to the well known skin disease, lichen planus. The type of skin lesions in the disease differs with the patient. The disease usually first occurs in itchy, oozing, reddish or purplish patches on the skin. These patches may remain the same for several weeks or they may spread rapidly. Some patients develop a later stage in which raised scaly patches appear, often on the arms and legs.

Following the acute stage of the disease, the inflamed patches leave purplish or brownish areas and often cause a temporary closure of sweat glands with a consequent lowered heat tolerance. In some cases patches of hair are temporarily lost.

## Disease in Enemy Occupied Countries

Tuberculosis and syphilis are the two most important health problems of liberated Manila, according to a bulletin released by UNRRA.

Based on returns for the first three months of liberation, the death rate for pulmonary tuberculosis as for a year has been calculated at 800 per 100,000 inhabitants, or about twenty times that of the average American city. In ten weks, 2,045 new syphilis cases were found among the civilian population, and the incidence continues to increase. Gonorrhea is equally prevalent. Manila was one of the few cities of tropical Asia where malaria had been reduced to a low level. During the Japanese occupation the disease returned and it now constitutes a serious problem. There has been no significant increase of other epidemic diseases.

War shattered cities in continental Europe are also suffering from serious epidemics. Pulmonary tuberculosis mortality has more than doubled in Rome. Epidemics of bacillary dysentery of a severe type and of typhoid fever are spreading in Berlin, where diphtheria, too, is once more on the increase. There were 1,100 cases of typhoid fever during the first three weeks of August. At Helsinki, Finland, there have been 2,472 paratyphoid fever cases up to September 6. Diphtheria remains widespread in the Netherlands where now one half of the cases occur among adults.

## Civilian Psychiatrists Report on Army NP Work in ETO

The commission of outstanding civilian psychiatrists appointed by the Office of Scientific Research and Development at the suggestion of The Surgeon General for a study of the Army's neuropsychiatric work overseas reported that as a result of prompt and skilled handling of combat exhaustion cases approximately ninety per cent of these men are returned to duty. Colonel William C. Menninger, director of Neuropsychiatry Consultants Division of the Office of The Surgeon General, has announced.

Members of the commission at a recent meeting in the Office of The Surgeon General were generous in their praise of the exceptionally fine psychiatric work that is being accomplished in the European Theater of Operations where they visited for eleven weeks, Colonel Menninger said.

The commission is composed of the following noted psychiatrists: Dr. John C. Whitehorn, chief psychiatrist, Johns Hopkins Hospital, and professor of psychiatry, Johns Hopkins University; Dr. John Romano, professor of psychiatry, University of Cincinnati College of Medicine; Dr. Lawrence S. Kubie, associate in neurology, College of Physicians and Surgeons, New York; Dr. Karl Menninger, director, Menninger Clinic, Topeka, Kansas; and Dr. Leo H. Bartemeier, professor of psychiatry, Wayne University, Detroit, Michigan.

In summing up his over-all impressions of the

European Theater of Operations from a psychiatrist's standpoint, Dr. Bartemeier said in the face of serious handicaps and hazards the Army psychiatrists are providing excellent medical service and the members all had "the greatest admiration for their courage, ingenuity and accomplishments."

He next mentioned that in the Army there was a closer and happier working relationship between the psychiatrists and the medical and sugrical services and the commanding officers than is usually found in civilian practice. Commanding officers overseas frequently mentioned how much they depended on the neuropsychiatric service.

Combat exhaustion cases, known as shell shock in the last war and sometimes referred to as combat fatigue or operational fatigue, are being treated more successfully in this war because of the high quality of personnel in the field, better methods and techniques, and of the greatest importance is the fact that our psychiatrists are getting to the men sooner than ever before, according to the findings of the commission. The Army psychiatrists are doing some of their most effective work right up near the front at the clearing stations.

There is some variation in the treatment given. Sedation, narco-synthesis, hypnosis, and the new technique of group psychotherapy were some of the methods of handling these battle weary soldiers. The results of group psychotherapy were, in general, particularly encouraging.

Dr. Menninger brought out the fact that an alert and understanding sergeant or lieutenant can anticipate a case of combat exhaustion. Symptoms are increasing irritability, lack of interest in letters from friends or family, lack of interest in comrades, and the throwing away of equipment and food. A man who has reached this stage, but who has not yet come to the breaking point can usually be brought back to normal with the help of a proper rotation plan to give the necessary rest and relief from the stress of battle.

There is a direct ratio between the number of exhaustion cases and the intensity of combat, Dr. Whitehorn pointed out. The number of combat exhaustion cases is almost always just about one-fifth the number of wounded cases.

Every man has his breaking point, according to psychiatrists. It is just a matter of how much stress and strain is put upon a man and for how long a period. The fact that combat exhaustion cases bear a direct ratio to the number of wounded shows that as the battle becomes more intense the pressure is just that much heavier, causing more men to reach the breaking point.

A factor that leads to combat exhaustion is the martyr situation, Dr. Whitehorn said. When men are unavoidably marooned from the main body of troops so that the situation seems hopeless, or when they are on a mission which they do not understand and which seems futile or when they are isolated and lose their leader, the average man is more likely to become subject to combat exhaustion under such circumstances.

The commission's report will stress the fact that combat exhaustion does not mean that a man is "yellow," or a coward. A big percentage of the combat exhaustion cases represent men who have had long months of service at the front as effective and brave fighting men. They simply come to the point where the human system can take no more. It is then that the psychiatrists start to care for the ailing soldier.

This commission will submit a formal report of its findings to the Office of Scientific Research and Development, Dr. Bartemeier announced.

## Promotions — Changes of Station

Denis S. O'Connor, associate professor of orthopedic surgery at Yale University, has been promoted to the rank of Captain in the U. S. Navy Reserve. Captain O'Connor was called to active duty December 16, 1941 as a Lieutenant Commander. He went overseas in June 1942, for duty with Mobile Hospital No. 4 in Auckland, New Zealand. He is now acting head of the U. S. Naval Hospital at Sampson, New York.

Major Frederick C. Weber, Jr. (Greenwich), has been promoted to Lieutenant Colonel.

Captain James S. Davis (South Norwalk), has been promoted to Major, station unchanged.

Major Maurice M. Pike, AUS (Hartford), has been promoted to Lieutenant Colonel. He is stationed at Dibble General Hospital, California.

Lieutenant Thomas M. Feeney, USNR (Hartford), has been promoted to Lieutenant Commander and is stationed at the Women's Reserve Barracks, Separation Center, N. Y.

## SIX PROJECTS FOR IMPROVEMENT OF ARTIFICIAL LIMBS

An intensified program for the improvement of artificial limbs which involves six separate projects will be undertaken by the Army in coordination with the National Research Council, according to an announcement by Major General Norman T. Kirk, Surgeon General of the Army.

In February of this year the National Research Council through its Committee on Prosthetic Devices, which comprises some of the country's outstanding scientists, started work on the problem of providing better arms and legs for amputees. Cooperating with this committee are the Veterans Administration, Navy, Army, National Bureau of Standards, Federal Security Agency and engineers from some of the nation's top industrial concerns.

The research activities of the Committee on Prosthetic Devices will continue along the same lines but the Army will give further cooperation in certain additional phases of the program. The plan of Army scientists is to complement what is being carried on under the National Research Council auspices.

The Army will conduct its research work at Army General Hospitals which are amputation centers. The presence in these hospitals of orthopedic surgeons who are handling these amputation cases and the clinical evaluation possible under such circumstances is expected to prove of definite value.

The aim of both projects is the general improvement in the quality of artificial limbs, more standardization of parts and the facilitation of production and fitting.

The six phases of the program in which the Army will devote its efforts include:

1. Further development and improvement of knee assembly and ankle assembly.

2. Investigation of materials for producing a cosmetic hand or for covering a mechanical hand.

3. Evaluation of usefulness of plastics in sockets or limb sections.

4. Broad study of metals and alloys used in fabrication or artificial limbs.

5. Investigation of fabrics and techniques of manufacture and fitting for protheses at or below the ankle.

6. Production of a motion picture record of the Army amputation and prosthetic program.

Private industry will play an important part in this program. The Committee on Prosthetic Devices of the National Research Council contracts with individual concerns for basic research which is carried on in the laboratories of the company contracted.

Northrup Aviation Company in California has done an outstanding piece of work in the improvement of a rotary wrist mechanism which gives an arm amputee far better use of the artificial hand. This work has been done in collaboration with Bushnell General Hospital at Brigham City, Utah.

The government authorizes payment for all expenses under these contracts and the Army through its amputation centers will afford every possible means of cooperation.

The War Department hopes to broaden this aspect of the project by enlisting the help of more industrial concerns which have the laboratory facilities to engage in such work.

An appropriation has been authorized sufficient to continue this Army project as long as The Surgeon General expects to have amputee cases in Army General Hospitals. There have been about 14,000 amputees in Army General Hospitals in this country since the beginning of this war. Of this total there are now about 8,300 amputees who are in the six amputation centers in Army General Hospitals.

Five per cent of these cases represent battle veterans who have two arms or legs or one arm and one leg, nine are triple amputees and only two men have lost both hands and both feet. Approximately 95 per cent are men who have suffered the loss of one limb.




YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Arthur B. Landry, Hartford
Burr H. Curtis, Hartford
Cole B. Gibson, Meriden

## AN OUT-PATIENT CLINIC FOR EXAMINATION OF VETERANS

Joseph H. Howard, M.D., *Bridgeport*

### THE PROBLEM

With the return of the veteran, some system for efficient and prompt medical care must be developed. It is to the advantage of the medical profession to develop this type of care rather than a new bureaucracy which will give inferior care at a great cost to the taxpayers. There are three methods of attacking this problem: first, by having the veterans return to the nearest Veterans Facility for examination; second, contract with various physicians to examine these veterans in their offices; third, conduct these examinations in the local hospital.

The disadvantage of the first is that considerable time is consumed by the veterans in returning to a particular Facility for examination. The disadvantage of the second method is that the veteran becomes dissatisfied in sitting around for a long period of time in a physician's office, and in those cases of multiple examinations it may be necessary to go from one office to another before the complete check-up is done. Also in case of laboratory work, further travel is necessary to the hospital or to private laboratories. It would seem, therefore, that the third method is most logical. The local hospitals have a competent staff of specialists, and in case laboratory work is necessary, it can be done at that time.

At the present time only service-connected disabilities are examined, but with the increasing demands upon the Veterans Facilities, it may be necessary not only to examine these veterans locally, but to treat them in local hospitals.

### ADVISORY SERVICE CENTERS

Most communities are now developing a Service Center of some type for the care of these veterans. The pattern in the larger cities follows that of Bridgeport which pioneered in this development. In small communities there may be some modification of this rather elaborate set-up. However, in all of them, there will be some part of that Center devoted to veterans. The description given here of the services conducted by a Service Center is that of Bridgeport, Connecticut, and may have to be modified depending upon the facilities and the size of the community. However, it might be well to aim at this ideal set-up.

The veteran reports to the Advisory Service Center at a particular hour. There he is examined by a full time veteran's physician, a complete history is taken, and a general physical examination is done. This screening process eliminates the necessity of the specialist in the hospital going into details of history and the general physical examination. The patient is referred to the hospital for particular, special examination. At the conclusion of the examination of a group of these veterans, they are then transported to the local hospital.

### OUT-PATIENT CLINICS

The local hospitals have been selected as the logical place to examine these veterans because we want these men to feel that their local community is interested in their problem. We want them to know their local doctors better, and to have a feeling for their local hospitals. This is definitely a community problem.

In spite of the fact that many hospitals in Connecticut have no out-patient department, this plan still will work well. In Bridgeport, at St. Vincent's Hospital where the plan has now been functioning for several weeks, there is no out-patient department, nor is there one in Bridgeport Hospital where the plan has been functioning for a shorter period of time. However, in this experimental field we find

that the veterans' out-patient department is functioning perfectly.

CLINIC HOURS

The hours may be adjusted in various communities, but in Bridgeport we felt that the hour between eleven and twelve was the most convenient. Most of the men have finished their rounds in the hospital by that hour, and experience has shown that this works very well. There are occasional instances where it will be more convenient to examine the veteran in a physician's office, such as for a complete eye investigation. These cases, however, will be rather rare.

In setting up the program, it is essential that the hour of examinations be convenient for most of the men. We are aiming at convenience for these veterans and prompt attention by the physician.

THE EQUIPMENT

No special equipment is necessary in this out-patient clinic. Special examinations are required in some instances, but in those cases, the patient can be transported to the x-ray department, or laboratory, for further examination.

Our experience in Bridgeport has been that the out-patient clinic should be not too far away from these laboratories.

STAFF OF THE OUT-PATIENT CLINIC

The staff should be made up of all specialists. In the larger communities where a large number of veterans are to be examined, it is well to have more than one man on each particular service.

Since we are striving for prompt and efficient care of these veterans, in case of sickness, vacation, or the physician being busy, it is well to have another man covering the service.

To obtain this staff, those who have services in the hospital and their assistants should be approached, the plan presented to them, and a request made that they fill out an applicatoin in duplicate to be presented to the Veterans Administration for their approval. The largest number of cases at present will require the services of an orthopedist, and a neuropsychiatrist.

In the beginning the Veterans Administration will refer a small number of cases. In Bridgeport we have started out with five cases per day, and since we have a coverage in both hospitals for six days each week, that number is quite small. As time goes on we shall increase this number to approximately twenty per day in each hospital.

RECORDS

In larger communities a full time medical secretary will be supplied by the Veterans Administration. She will be present at the hospital during these examinations and will take the notes of the physicians and will type them. The physician, therefore, will glance through the notes and sign his name. This eliminates a large part of paper work for him.

This medical secretary will also notify the hospital some time before the clinic as to the number and type of patients which will appear on that particular day, so that each physician will know whether or not he has particular cases coming in at that time.

Someone in the hospital must assume the responsibility of receiving the notification from the Advisory Service Center and advise the physician as to the particular day he shall appear to examine selected patients.

The medical secretary will also have charge of the bills. At the end of each month she will notify each physician of the number of men he examined, and he in turn will send a bill to the hospital, which will act as an agent for the Veterans Administration. The hospital will receive a check from the Veterans Administration for all the work done during that month, and upon receipt of the physician's bill, will mail him a check for the work completed.

FEES

From time to time we hear remarks from physicians regarding the fee schedule. There are very few physicians in the State who have seen the list of fees, but shortly it will be mailed to all those men who are doing this veterans' work.

In some instances the fee seems smaller than the usual private practice fee. In other instances it is comparable to that which a physician receives in private practice. However, in a program of this type, when the doctors begin to emphasize fees, it nullifies the whole public relations program through which this is being carried out. This is our contribution to a good cause, and there should be no question by any physician as to whether or not the particular fee he is receiving is a bit lower than that he receives in private practice.

This plan has been developed in one community in Bridgeport, and is functioning in a satisfactory manner to the physicains and to the veterans. Let us adopt such a plan in the State so that Connecticut may again lead in constructive medical care.

# WOMAN'S AUXILIARY

## TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, Mrs. James Raglan Miller, Hartford
*President-Elect*, Mrs. James Douglas Gold, Bridgeport
*First Vice-President*, Mrs. Creighton Barker, New Haven
*Second Vice-President*, Mrs. H. Bertram Lambert, Southport
*Recording Secretary*, Mrs. Charles W. Goff, West Hartford
*Corresponding Secretary*, Mrs. Edwin R. Conners, Bridgeport
*Treasurer*, Mrs. Julian G. Ely, Lyme

### FAIRFIELD COUNTY

The Board of Directors of the Woman's Auxiliary to the Fairfield County Medical Association held a meeting on Monday, September 24, at the residence of Mrs. James Douglas Gold, 839 Myrtle Avenue, Bridgeport. Mrs. Gold, county president, presided.

Mrs. J. Grady Booe, program chairman, announced that the fall meeting would be held in the Connecticut Power Company auditorium, 429 Atlantic Street, Stamford, on Tuesday, October 30, at 2:00 P. M. Dr. Stanley B. Weld, editor of the Connecticut State Medical Journal, would be the guest speaker, his subject, "Cancer Control."

Mrs. Gold announced the appointment of Mrs. Francis G. Finderak as War Participation chairman and Mrs. John Peter Simses, as chairman of Telephone Committee.

At the conclusion of the meeting tea was served by Mrs. Gold.

### HARTFORD COUNTY

The meeting of the Board of Directors of the Woman's Auxiliary to the Hartford County Medical Association was held on October 3 at the home of Mrs. C. W. Goff. Plans for the semi-annual meeting on October 23 were discussed, the meeting to be held at the Hartford Club.

Mrs. Jones, chairman of State War Participation Committtee, brought to the attention of the Board problems of physicians returning from service in the armed forces, such as scarcity of business offices and immediate living quarters. It was suggested to prepare and keep a file of available offices in this city and of physicians' homes offered to doctors for a short stay. Mrs. Landry, president, appointed a special sub-committee to survey this situation and to work in cooperation with the War Emergency Committee of the Hartford County Medical Association.

Assistance in the work of the Connecticut Society for Crippled Children and Adults was also brought to the attention of the Board. The Board voted to have the president appoint a special committee on volunteers to assist the crippled children and adult's program as well as such other programs of that nature that may be approved by the Board.

### NEW HAVEN COUNTY

Woman's Auxiliary of the New Haven County Medical Association held a Board of Directors meeting, Monday, October 1, in the New Haven Medical Association Building. Mrs. Luther K. Musselman, president, presided at the meeting. Officers and chairmen attending were as follows: Mrs. Eugene M. Blake, first vice-president; Mrs. Simon B. Kleiner, second vice-president; Mrs. Paul W. Vestal, recording secretary; Mrs. Frank DiStasio, corresponding secretary; Mrs. Joseph L. Hetzel, treasurer; Mrs. Frederick Roberts, chairman of War Participation; Mrs. Edward T. Wakeman, membership chairman; Mrs. Barnett Freedman, chairman of Constitution; Mrs. John B. Foster, chairman of Legislature; Mrs. Creighton Barker, chairman of Nominating Committee; Mrs. Arthur H. Morse, chairman of Program; and Mrs. Herbert Thoms, chairman of Hospitality.

The Woman's Auxiliary of the New Haven County Medical Association held its annual Fall meeting, Thursday, October 25, at the Waterbury Medical Association Building, Waterbury. Mrs. Luther K. Musselman, president, presided at the business meeting. Mrs. Arthur H. Morse, chairman of the program presented the guest speakers. Creighton Barker, M.D., secretary of the Connecticut State Medical Society, spoke on "Legislative Medicine." Miss Elizabeth S. Bixler, dean, Yale University School of Nursing, spoke on "The Nursing Education."

A tea followed the meeting, Mrs. Sidney Jennes of Waterbury being the hostess.

# OBITUARY

## Philip Joseph Savage, M.D.

### 1893 - 1945

Major Philip Joseph Savage was born in New London, Connecticut, June 9, 1893 and received his early education at Saint Mary's Parochial School and Bulkeley School of this city. He then attended Colgate University and became interested in medicine, continuing his education at the University of Maryland where he received his M.D. degree. His first interests were largely devoted to obstetrics and upon his return to New London he served as assistant obstetrician on the staff of The Lawrence and Memorial Asssociated Hospitals for several years. At this time he decided to forsake general practice and obstetrics, and to specialize in diseases of the eye. His studies were continued at the Royal London Eye and Ear Hospital in England, following which he returned to New London in this specialty.

Major Savage was always active and interested in Military service. He served with the Depot Brigade during World War I and in August 1927 he joined the Connecticut National Guard and received a commission as Captain in the Medical Corps, being attached to the 192nd Field Artillery. He continued actively in the National Guard and was inducted into Federal Service February 1941, receiving his commission as Major.

At the outbreak of World War II he continued his training with the 43th Division at Camp Shelby, Mississippi and was subsequently assigned to the Army Air Corps. He saw duty in England and the African invasion. He contracted amebic dysentery while overseas and from then on his health became considerably impaired. Some time later he underwent a colostomy for a neoplasm of the rectum.

He had planned to continue his practice in New London as an eye specialist but his illness had progressed to such an extent that he was unable to continue to work. He gradually failed and died August 2, 1945.

Richard M. Starr, M.D.

## Council on Pharmacy and Chemistry Report on Dermatophytosis

A special committee comprising four authorities on infections of the feet was appointed by the Council on Pharmacy and Chemistry of the A. M. A. This committee's report appeared in the July 14 issue of *The Journal of the American Medical Association*. Some of the conclusions in this report are of particular interest.

1. The hygiene of the feet is paramount both in the prophylaxis and treatment of dermatophytosis.

2. The "old reliable" Whitfield's ointment, and also boric acid powder, stood up well as fungicide preparations when compared with newer ones like sodium propionate and Cresatin.

3. Bacteria is believed to be an important cause of many infectious intertrigos formerly considered mycotic.

4. Other foot conditions are due to sensitization to local applications such as shoe polish and medicaments, and to long standing hypostasis and trauma.

5. Repeated attacks of dermatophytosis are believed to be recurrences rather than reinfections.

6. Foot baths are becoming discredited.

7. Dermatophytosis does not predispose to contact dermatitis.

8. Buerger's disease is an allergic expression of dermatophytosis.

9. A standard method for testing fungicides, at least for dermatophytosis, is being developed, and an outline has been submitted for the clinical evaluation of fungicides which should be useful to manufacturers and others.

## An Oklahoma City Physician Writes From Overseas

It is a grand feeling to know that some one at home is working for good medicine. . . . Many of us here hope that socialized medicine never comes, as we are fighting for something in principle so foreign to socialized medicine. I would hate to believe that my long stay on foreign soil has been in vain. I am proud to be a part of this great Army, and, if I do say so, I believe I have been a good soldier, which I realize is necessary for efficiency. When this affair is over I would like to practice medicine my own way.

# SPECIAL NOTICES

## INTERNATIONAL COLLEGE OF SURGEONS MEETS IN WASHINGTON

The International College of Surgeons will hold its Tenth Annual Convention and Convocation on December 7 and 8, 1945, at the Mayflower Hotel, Washington, D. C. At this time approximately 200 men will receive their Fellowship. A scientific program is arranged for both days. Convocation exercises will be held Friday evening, December 7, in the Mayflower Auditorium.

## POSTGRADUATE COURSE IN RADIOLOGY ANNOUNCED FOR PHILADELPHIA

The first of a projected series of regional postgraduate courses to be sponsored by the Commission on Education of the American College of Radiology in conjunction with selected teaching institutions will be conducted during the week of February 4, 1946, at the Philadelphia County Medical Society Building in Philadelphia. This first and experimental course, patterned after similar courses conducted by the American College of Physicians and the American College of Surgeons, will be jointly sponsored by the American College of Radiology and the Philadelphia Roentgen Ray Society.

Dr. E. Pendergrass is chairman of a sub-committee appointed by the Commission on Education to conduct the course. Assisting him are the following Philadelphia radiologists: Drs. Robert P. Barden, Ralph Bromer, Edwin L. Lame, J. Francis Mahoney, Calvin Stewart, Paul Swenson, Bernard P. Widmann, and Barton R. Young.

A registration fee of approximately $50 will be charged. The funds thus secured will be used to defray the expenses of speakers brought from outside Philadelphia, administration expenses, and for one or two social events. Registration will take place on Sunday, February 3, 1946, from 2 to 5, at the Philadelphia County Medical Society Building.

The names of teachers participating in the course, which will consist of post-graduate clinics in therapy, will be announced. Following is the program:

Monday, February 4—The entire day is to be devoted to a practical consideration of therapy problems concerned with the physics of radium and roentgen rays.

Tuesday, February 5—Carcinoma of the female genital tract.

Wednesday, February 6—Carcinoma of the breast.

Thursday, February 7—Carcinoma of the head and neck. The Philadelphia Roentgen Ray Society meeting is in the evening.

Friday, February 8—Carcinoma of the skin, morning session. Treatment of infections, afternoon session.

Saturday, February 9—Radiation treatment of blood dyscrasias and lymphoblastomas, morning session. Cancer detection clinics and important developments in cancer research, afternoon session; banquet, evening.

It is proposed to give each registrant a mimeographed outline of the entire course. The program will be arranged to permit a round-table discussion of practical problems. Subjects to be presented will include the pathologic, clinical, and therapeutic aspects of the conditions under consideration. Teachers will be drawn from the fields of radiotherapy, surgery, oncology, physics, biophysics and pathology.

Advance registration may be made by writing to the Commission on Education in care of the American College of Radiology. The number of registrants will be limited.

## AN ABSTRACTING SERVICE FOR HUMAN BIOLOGY

The Trustees of *Biological Abstracts* announce the establishment, beginning in January, 1946, of a new section of *Biological Abstracts*—Section H, specially assembled Abstracts of Human Biology—intended for anthropologists, sociologists, psychologists, neurologists and psychiatrists, students of child development and human welfare, and students of man generally.

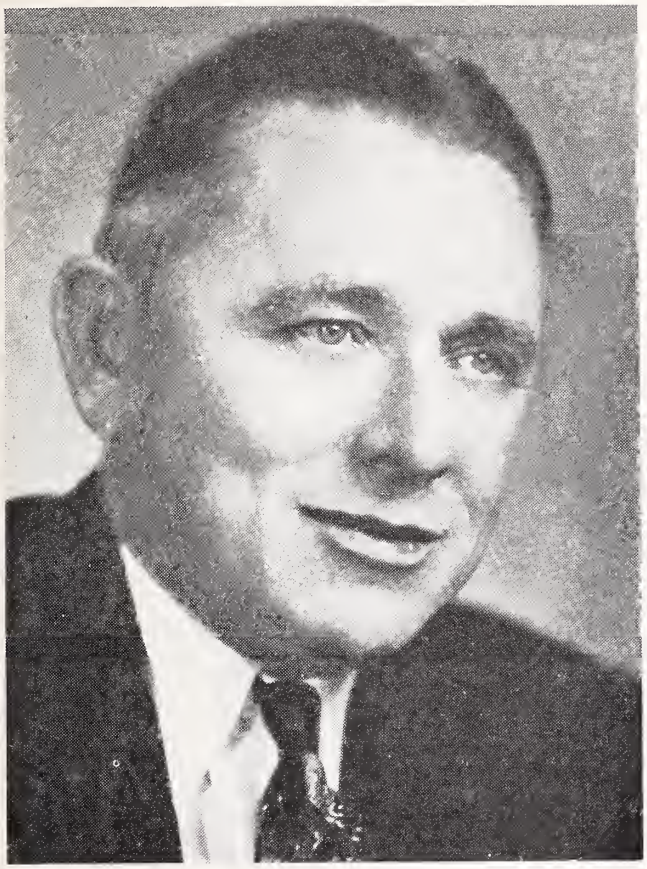
The new section will be an assemblage of all abstracts published in *Biological Abstracts* dealing with the broad field of human and social biology. Biological studies on human inheritance, on population and fertility, on endocrine and neurological factors affecting growth, development and human personality, on alcoholism and drug addiction, and on nervous disorders and mental deficiencies, and broad nutritional and epidemiological studies affecting human welfare, are some of the many fields that will be covered. The annual subscription price for the ten abstract issues, plus the complete index of the year's volume of *Biological Abstracts* will be $6.00 ($6.50 outside the United States).

Full information may be obtained by writing to Mr. H. I. Anderson, Business Manager, *Biological Abstracts*, University of Pennsylvania, Philadelphia 4, Pennsylvania.

## PHYSICIAN-ARTISTS' PRIZE CONTEST

The American Physicians Art Association, with the cooperation of Mead Johnson & Company, is offering an important series of War (Savings) Bonds as prizes to physicians in the armed services and also physicians in civilian practice for their best artistic works depicting the medical profession's "skill and courage and devotion beyond the call of duty."

For full details, write to the Association's Secretary, Dr. F. H. Redewill, Flood Bldg., San Francisco, Cal., or Mead Johnson & Co., Evansville 21, Ind. Also pass this information on to your physician-artist friends, both civilian and military.



## Edwin J. MacEwan New Administrative Director of American Cancer Society

Edwin J. MacEwan's appointment as administrative director of the American Cancer Society was announced on October 3. The office is newly created and carries full responsibility for the business management of the cancer organization which is national in scope with affiliates in virtually every state in the nation. It became effective October 15.

Mr. MacEwan resigned as executive vice-president of the New Haven, Connecticut, Chamber of Commerce to accept this new position with the American Cancer Society.

He headed the first annual campaign of the American Cancer Society in Connecticut last year, and when the drive closed Connecticut led all other states on per capita contributions.

Mr. MacEwan came to the New Haven Chamber of Commerce early in 1944 from Quincy, Massachusetts, where he had served as executive secretary of the Chamber and as executive director of the Community Fund. He conducted a campaign that doubled the Chamber's budget and nearly doubled its membership. He has been much in demand as a speaker on business subjects throughout New England and as a consultant on organization procedure. He organized the Sales Managers Club, Foreign Trade Club, Women's Traffic Club and many other groups within the Chamber. Last year he was appointed Connecticut member of the five-man Committee on Housing, by the Board of the Federal Home Loan Bank of Boston. He set up a coordinating office of the Department of Foreign and Domestic Commerce and a local office of the Inter-American Affairs Committee.

## NUTRITION REPORT ON CIVILIAN INTERNEES OF JAP PRISONS

American civilian internees of Japanese prison camps in the Philippines, who have recently been returned to the United States, were found in a survey by nutritional scientists of the Army Medical Department to be on the borderline state of extreme starvation.

According to the report, the food served the prisoners, in addition to being poorly cooked, consisted mainly of wilted greens, moldy corn, dirty rice, and a variety of sweet potato, which was often rotten. This soon led to vitamin deficiency diseases. Relief packages were allowed in the camp only twice during the period of internment, all market vendors were barred from the camp, and the only source of extra rations was the black market.

The report, in listing the effects of malnutrition on the eight children born in the prison camps, noted that only three showed any signs of vitamin deficiency. This was attributed to the mild climate and sunshine of the Philippines. The average weight loss, during the time of internment, jumped from 13.5 pounds in 1942 to 20 pounds in the last six months before liberation.

The most common symptoms still evident in the liberated Americans is digestive upsets, easy fatigability, and neuritis. Seventy-eight per cent of the internees, however reported that they felt "fine" a few days after liberation. The rapidity of recovery of the adults and the relatively good condition of the children is a striking example of how quickly the human body will return to normal after semi starvation.

**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)

## Prepayment Plans Growing

Records continue to be broken in the number of Americans joining voluntary non profit plans for prepaying hospital bills. A total of 2,282,482 new members joined during the first six months' period of 1945 and thus exceeded by more than 500,000 the previous record membership growth established during the corresponding period of 1944.

This announcement was made July 27 by Dr. C. Rufus Rorem, director of the American Hospital Association's hospital service plan commission, who stated that the total Blue Cross membership in 43 states, the District of Columbia, 7 Canadian provinces, and Puerto Rico now numbers 18,800,000 Americans.

Whereas a year ago, new members were enrolling nationally at the rate of approximately 12,000 per working day, the rate has now increased to almost 17,000 persons daily. More workers and family dependents joined Blue Cross during the first six months of 1945 than joined during the entire year of 1942.

Six states have passed the million membership mark. New York State leads with over 3,000,000 Blue Cross members; Ohio, 2,160,000; Pennsylvania, 1,933,000; Michigan, 1,303,000; Illinois, 1,222,000; and Massachusetts, 1,202,000.

A state-wide Blue Cross plan has just been approved for New Mexico which leaves only Arkansas, Mississippi, South Carolina, Idaho, and Wyoming without a community and hospital sponsored plan for removing the financial worry of hospitalized illness or injury.

Doctor bill prepayment plans sponsored by state and county medical societies and made available to the public through coordination with Blue Cross hospital service plans increased in number from 19 to 24 during the first six months of 1945. Membership in these medical plans now totals 1,800,000 Americans.

WANTED

Resident Physician for 173 bed approved hospital in New England in college town of 25,000. Resident to cover all services and assist in teaching program of interns. Single maintenance and salary of $2,500 to $3,000 a year. Apply Box No. C, Connecticut State Medical Journal, 54 Church Street, Hartford 3, Conn.

# OUR NEIGHBORS

## Massachusetts Medical Service Extends Benefits

Massachusetts Medical Service, established by the Massachusetts Medical Society, reports that a recent survey showed that this plan had a larger net enrollment for the first quarter of 1945 than any other medical society plan in the country. Nearly four-fifths of the actively practising physicians in Massachusetts participate in the plan. The enrollment as of July 1, 1945 was about 150,000 subscribers. On this same date a surplus had been acquired of $225,000 required by the Commissioner of Insurance before expansion could be carried out. Massachusettts Medical Service is now ready to add to its contract medical care in the hospital without increasing the premium rate.

## United Medical Service Launches "All Coverage" Medical Plan

*New York Medicine* informs us that United Medical Service, Incorporated, announced on September 4 the launching of the first all-inclusive medical care insurance plan ever offered in the New York metropolitan area. The new plan comprises a group contract for the provision of medical, surgical and maternity care including after-care in the home and doctor's office as well as in the hospital. This contract will be limited to a maximum of 25,000 persons already enrolled in groups of fifty or more in Associated Hospital Service of New York until further expansion has been justified on the basis of actual experience. During the present trial period groups will be selected from widely separated communities in the seventeen counties covered by the plan. Contracts for the service which would provide full coverage for families with incomes up to $2,500 or single individuals with incomes up to $1,800, will be issued to employers instead of the individual subscribers as in previous plans. Families with incomes above $2,500 or individuals whose incomes exceed $1,800 will be entitled to partial payments against their medical expenses on the indemnity principle.

The rates for the expanded service will be $1.60 a month for individuals and $4 a month for husband



## All in favor raise right hands . . . *with wallets*

**Naturally we want** our boys home. The sooner the better.

But how much are we willing to do about it?

Are we willing to pay for bringing them back? If we are, we'll buy *extra* Bonds in the Victory Loan.

And after these fellows get home—these men who have fought and won the toughest war America has ever known—what then?

**We want to take care** of the injured ones, of course. We want to see that the young fellows who went off to fight get a chance to finish their education. We want to see that there are jobs—plenty of decent jobs—for the men who've been doing the world's meanest job at army pay.

How much are we willing to help?

If we're really serious about wanting our men to get what they have so richly earned, we'll buy *extra* Bonds in the Victory Loan.

**Now's the time.** Let's have a show of hands—with wallets—to prove how much we really want to hear that old familiar step and that familiar voice yelling "It's *me!*" Let's prove, with pocketbooks, that we can do our job as well as they did theirs.

**THEY FINISHED THEIR JOB—**
**LET'S FINISH OURS!**

VICTORY LOAN

and wife including any number of unmarried children under 18 years of age. Subscribers will be entitled to one visit a day from a general practitioner up to as many as 20 visits for any one illness, injury or pregnancy case. Additional visits may be authorized. An outstanding feature of the new contract is a provision which entitles subscribers to specific payments towards the services of qualified specialists.

United Medical Service will pay the participating physician $2 for each visit from a subscriber to his office and $3 for each visit he makes to the patient at home or in the hospital. For any call received after 8:00 P. M. the physician may make an additional charge which will not exceed $2 for subscribers in the lower income brackets.

Specialist services are provided when the subscriber is referred to a qualified specialist by his attending physician. In these cases U.M.S. will pay the specialist 50 per cent toward an established base rate fee which, in most cases, is equal to the Compensation schedule of fees. The specialist will not charge more than the remaining 50 per cent to subscribers with family incomes under $2,500.

The new "all-coverage" plan is being offered to a limited number of subscribers to test its feasibility until such time as sufficient data has been accumulated for actuarial calculations and conclusions. The contract to be written under this plan will be spread out over as wide an area as possible in order that no one physician will be likely to have more than a few subscriber families as patients at this time.

U.M.S. now has approximately 137,000 subscribers who are covered by more limited plans. More than 8,000 physicians are now cooperating in the combined U.M.S. program.

## New York University Aids Veterans

New York University College of Medicine is making plans to contact and recruit a group of young men now on duty in the armed forces who may develop into investigators and teachers of medicine. They will be offered the privilege of becoming affiliated with various departments of the medical college with opportunity for research and participation in teaching and hospital assignments. Among medical officers returning to New York University College of Medicine for advanced or refresher courses, the demand for longer courses is greatest from graduates of the last five or six years, the so-called "lost generation." Requests for short courses come chiefly from older physicians.

Obtaining the library of the late Dr. J. G. M. Bullowa, New York University College of Medicine has been able to complete the files of important journals for its main library and various departments of the college. Some rare old volumes were among the material received.

# NEWS
## *from County Associations*

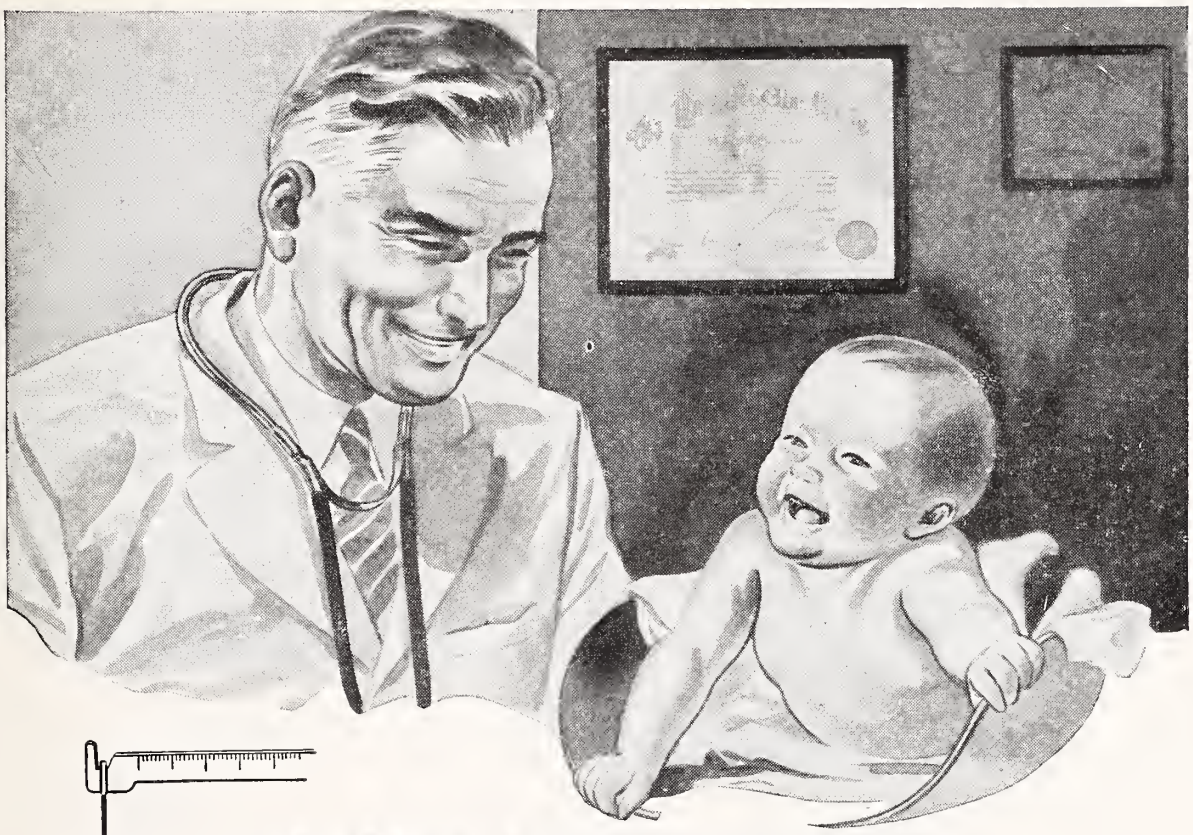
### Fairfield

The 154th semi-annual meeting of the Fairfield County Medical Association was held on Wednesday, October 3, at the Ridgewood Country Club in Danbury. It was one of the most interesting and enjoyable meetings ever held by the Association. During the business session in the afternoon John D. Booth of Danbury, the vice-president, gave a very interesting account of "The Candlewood Murder Case," in which case he had acted as medical examiner. The after-dinner speaker was Benjamin Reynolds Reiter of Bridgeport, a member of the Association who has just been discharged after more than three years of service with the armed forces. His subject was "War Surgery" and he gave a most illuminating and interesting account of what had been accomplished by the medical profession in the theatres of war where he served.

Lt. Col. Chester Haberlin of Stratford, has arrived from France on sick leave. He is stationed at Walter Reed Hospital.

Sally Anne Buxton, daughter of Mr. and Mrs. F. Murray Buxton, of London, England, who arrived here five years ago at the age of two when England was being "blitzed" by the Nazis will soon leave the home of Major and Mrs. Sidney Chipman. The Chipmans were the first Norwalkers to receive into their home an evacuee from London. Major Chapman, one of Fairfield County's pediatricians, entered the Army three years ago and has been overseas almost eighteen months.

Lt. Cmdr. Twachtman (Eric), spent fifteen months' duty on a destroyer and headed the radiology department of the 2,500 bed hospital at Fanajut, Idaho. Last January he left for the Pacific. He went into Okinawa with the first wave and was then atached to the 27th Infantry Division, receiving a



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letter of commendation from General Simon Buckner for his work. Still on Okinawa he writes—"Am doing a lot of major surgery. Last week we treated 20,000 patients in that clinic alone, not counting my little hospital on the beach. I also run a 'Lying In' Hospital in addition to innoculating 12,000 people for this and that."

Captain Roy Robison is now back in this country doing surgery at the Station Hospital, Fort Hamilton, Brooklyn, New York. In February, 1942 he went to Iceland with the 208th General Hospital and after eighteen months there he returned to this country. He then spent a year in the Pacific. He was attached to part of the Yale unit in New Zealand. This past winter he made trips on the Queen Elizabeth, bringing patients home from England.

## Hartford

Lieutenant Colonel Arthur E. Unsworth, AUS, of Hartford is the author of "A Discussion of Ocular Malingering in the Armed Services" published in *American Journal of Ophthalmology*, February 1945.

Henry B. Rollins of Hartford, associate medical director of the Connecticut Mutual Life Insurance Company since 1931, has been named medical director to succeed Charles B. Piper of Hartford who becomes director emeritus.

## Litchfield

The Litchfield County Medical Association held its regular semi-annual meeting on October 2 as the guests of the Maggi Company in New Milford. Members of the Society and the members of the Woman's Auxiliary were royally entertained by the officials of the Maggi Company in the spacious New Milford plant.

Following a delightful dinner and an interesting tour through the plant, the regular business meeting was held, presided over by the president, Donald Herman of Winsted. Joseph Howard, president of the State Society, spoke briefly urging the physicians to cooperate in reinstating returned veterans into the practice of medicine. President-elect Cole Gibson briefly extended his greetings to Litchfield County. Creighton Barker, State Society secretary, completed his talk to the Woman's Auxiliary in time to put in an appearance and spoke concerning the number of men who had been in the service and concerning their chances for returning to civilian practice. Major Burnham, representing the Connecticut Re-employment Bureau, spoke briefly concerning the work of this bureau and how the physicians of the state could best cooperate with it. James Raglan Miller, chairman of the Council, discussed some of the national legislation which affect physicians. Albert Brewer of Salisbury was the only new member elected.

The motion was passed to have the president appoint a committee to go into the matter of establishing a memorial to Frank Richenbach in the new State Medical Building. Dr. Herman appointed to this committee Winfield White, Edwin Read, and Arthur Jackson. He also appointed a committee consisting of Thomas Danaher, Bradford Walker, and Richard Barstow to revise the by-laws of the organization.

## Middlesex

The annual meeting of the Medical Board of the Middlesex hospital was held on October 10. Harry S. Frank was elected president, Louis O. LaBella vice-president, F. Erwin Tracy secretary. The Board welcomed back three members of the staff recently discharged from the service. Norman Gissler, a Lieutenant Commander, and Clair Crampton, a Lieutenant, senior grade, both saw sea duty in the South and Central Pacific while serving in the Medical Corps of the Navy. Willard Buckley served in the African and European Theater of Operations as a Captain in the Medical Corps of the Army. He is the recipient of seven battle stars.

Stanley Alexander of Portland, a member of the staff of the Middlesex Hospital, is doing three months postgraduate study at both the Bellevue and Lincoln Hospitals in New York City.

Charles A. Russman, assistant superintendent at the Connecticut State Hospital in Middletown, is taking part in a two months' teaching and study program at the Walter E. Fernald State School in Waverly, Mass. He will resume his duties at the State Hospital on December 10.

Mario Palmieri, for several years full time health officer of Middletown, has resigned to begin the private practice of medicine. He has opened an office on Broad Street in Middletown.

Benjamin Shenker, a former resident at the Middlesex Hospital and a Captain in the Medical Corps of the U. S. Army for the past four years, has received his army discharge. He has opened his office on Main Street in Middletown for the private practice of medicine.




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The Central Medical Society held its first meeting of the season on October 9 at Bengston Wood Hall. Anthony Mendillo of New Haven discussed recent developments in the field of general surgery. John Brody discussed anesthesia with particular reference to the use of pentothal sodium, nitrous oxide and curare in abdominal surgery.

The Middlesex County Medical Association held its semi-annual meeting at the Edgewood Country Club in Cromwell on October 11. Colonel James M. Quinn discussed at considerable length the Connecticut Plan for community organization for the veteran. Joseph Howard, president of the State Society, discussed among other subjects the plan in use in Bridgeport for the medical care of the veteran and expressed the desire that this plan might be adopted in other communities. Lieutenant Colonel James C. Fox of New Haven talked of the work of the 39th General Hospital in Aukland, New Zealand. He was with this unit for several months and discussed the administrative and research programs carried on there. He also discussed his work as a medical officer at the Cushing General Hospital after his return to this country.

## New Haven

A number of physicians have returned and are opening their offices again. Among them are Pat Piccolo, F. W. Roberts, Verstandig, and Angelo Gentile. Dr. Verstandig has been released from the Army as head of the Induction Center and is opening an office for radiology in New Haven.

Max Berlowe has returned and is opening his offices for the practice of gynecology and obstetrics. Orvin Hess has returned and is also engaged in the practice of gynecology and obstetrics.

O. J. Bizzazzero has recently been discharged from the Army. He served most of his time in Italy.

Bernard Berman, Reymond Markle and Edo Passetto have recently spent furloughs in Waterbury.

## New London

The semi-annual meeting of the New London County Medical Association took place on Thursday, October 4, at Uncas-on-Thames. The business session started at 4:30 P. M. with John F. O'Brien in the chair and was most interesting. Reports from the various committees showed the Society very much alive and progressing. Following the routine business much attention was paid to a studied presentation by William F. Wiedmann on the advisability of enlarging the Council so that each county would have two members instead of one. A committee will be appointed by Dr. O'Brien to study this matter. Present at the meeting was Mr. Charles M. Morgan, veteran advisor of New London and Waterford who spoke of the problems of the returning veteran and urged that the Medical Society take an active part in his program. Dr. O'Brien will appoint an advisory committee to confer with Mr. Morgan.

It was a great privilege to welcome Joseph H. Howard, our State Society President, who told us in clear language just what the State Society is doing and what is being planned. Also a great pleasure to welcome J. R. Miller, chairman of the Council, who told us of the workings of that body. Also, as always, Creighton Barker was welcomed and in his characteristic way presented his part in the State Society. It was a great privilege and pleasure to welcome these men. Following the business meeting, a fine turkey dinner was served in the new building. Our thanks to Dr. Wiedmann and his staff.

Following the dinner an excellent scientific paper was presented by John R. Paul of New Haven on "Poliomyelitis." It was an excellently prepared paper on this present unsatisfactory problem. Discussion was opened by W. T. Driscoll and C. G. Thompson, followed by many questions and a general discussion. Our November meeting will be held at Uncas-on-Thames at which time we shall have Edward G. Waters, Margaret Hague Hospital, Jersey City, who will present a paper on "Practical Anatomy of Gynecological and Obstetric Problems."

Mario Albamonti, recently discharged from the Army, will resume practice in Norwich on November 1.

Dwight S. Danburg, a graduate of University of Louisville Medical College, recently joined the staff of Uncas-on-Thames as an assistant physician.

Ralph W. Ballin is leaving Uncas-on-Thames on October 15 to join the staff of the State Sanatorium in Maryland. Our best wishes go with the good doctor.

Shirley Baron, Commander, MC—USNR, was a visitor in New London this week. Dr. Baron, who saw several years active service in the Pacific Theater of war as a nose, throat, ear and bronchoscopic specialist, expects to be discharged from the Navy December 1, 1945, and will enter private practice in San Francisco, California.

Carl Wies of New London, Connecticut, Lt. Col., General Staff Corps, AUS, has been discharged from

the U. S. Army and has resumed the practice of Internal Medicine, at 58 Huntington Street, New London.

Plans are being made for an addition to the Lawrence Memorial Hospital, New London, to house an x-ray therapy unit and tumor clinic. As soon as building material and technical equipment is available the erection of the new addition will begin.

### Tolland

Rockville City Hospital closed the doors of its old home on October 9. In a short time, it will reopen in its new home on Union Street. On the last night in the old hospital a dinner was held there, attended by the medical and nursing staffs. Mrs. Gladys Cratty, who was a nurse at the hospital when it opened, told about some of the hardships and thrills of a new hospital. The evening was rounded out with talks by the members of the staffs, and with the reading of an original poem, "Farewell," by Mrs. Dinah Herzog, a hospital employee.

## News from Yale University School of Medicine

The Yale Medical Society held its first regular meeting of the fall term on the night of October 10. The meeting was devoted to presentations by members of the faculty, whose topics were as follows:

The Complement Fixation Test in Lymphogranuloma. By Marion E. Howard, Olive R. Benham and Earle K. Borman.

Relation of the B Vitamins to Ovarian Function. By Victor A. Drill.

An investigation of the Nature of the Morbid Changes in Peritonitis, With Particular Reference to the Significance of Circulating Fibrinolytic and Antifibrinolytic Factors. By John H. Kay and John S. Lockwood.

The regular Thursday afternoon series of seminars in pharmacology was begun on October 11 in the Sterling Hall of Medicine. B. E. Lowenstein spoke on The Pharmacology of Some Adrenal Steroids.

On Thursday, October 18, Colonel Daniel C. Elkin, who is chief of surgery at the Army's Ashford General Hospital, addressed a special meeting of the Yale Medical Society on the subject of arteriovenous fistula.


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# NEW BOOKS IN REVIEW

*BACILLARY DYSENTERY, COLITIS, AND ENTERITIS.* *By Joseph Felsen*, M.D., Director of Medical Research, Bronx Hospital, New York; Director of International and Pen-American Dysentery Registry. *Philadelphia, Pa.: W. B. Saunders Co.* 618 pp. illustrated, 9 in colors. $6.00.

Reviewed by M. Tager

Dr. Felsen has played a major role in making the American medical profession alert to the nature and extent of Shigella infection in the United States. He has not only contributed widely to the knowledge of this infection, but has pioneered in efforts at prevention as well through such activities as the founding of the "International Dysentery Registry." This comprehensive volume represents not only his own point of view, but also a synthesis of the facts on the current state of the problem. While the bacteriology, pathology, epidemiology, and other pertinent phases are fully discussed, the overall emphasis is clinical. Nowhere else will the reader find a more complete and practical presentation of Shigella infection, and the well over 2000 references bear witness to the thoroughness with which the literature has been combed. In his discussion of acute bacillary dysentery, the author emphasizes, as Craig has done for amebiasis, that dysentery is only one manifestation of the infection, that the same organisms probably constitute the most important cause of mild diarrhea as well, and that even such atypical manifestations as the appendicular, meningeal, arthritic, and pneumonic syndromes may be based on Shigella infection. One need not accept, however, the author's contention that hypothetical toxins are responsible for such clinical pictures. The reader who is familiar with Felsen's studies during the past decade, will not be too startled to find chronic ulcerative colitis and regional ileitis considered as chronic manifestations of Shigella infection. The author is one of the few who has actually traced cases of acute bacillary dysentery into clinical states indistinguishable from chronic ulcerative colitis and regional ileitis. However, while, in the light of such evidence as the author is able to muster, one cannot any longer doubt that some cases may be on the basis of specific etiology, the question remains open as to precisely what fraction of these disabling chronic diseases is due to Shigella, and to what extent other factors may be involved. While some of the author's conclusions are open to alternative interpretations, this in no way detracts from the inherent value of the work as the most complete and useful presentation of the subject available.

*ONE HUNDRED YEARS OF GYNAECOLOGY.* *By James V. Ricci*, A.B., M.D., Clinical Professor of Gynaecology and Obstetrics, New York Medical College; Director of Gynaecology of the City Hospital, New York; Director of Gynaecology and Obstetrics, Columbus Hospital; Attending Gynaecologist and Obstetrician, Flower and Fifth Avenue Hospitals, New York; Consultant in Gynaecology and Obstetrics, Downtown Hospital, New York; Fellow of the New York Academy of Medicine. *Philadelphia: The Blakiston Company.* 1945. 651 pp. $8.50.

Reviewed by Stanley B. Weld

The author previously covered the history of gynecology from 2000 B.C. to 1800 A.D. in his book entitled, "The Genealogy of Gynaecology." The present volume completes the historical background of this specialty, supplying data up to 1900. It is a stupendous undertaking, because, as the author rightly reminds his readers, "the Gynaecological literature of the first half of the nineteenth century is immense; of the latter half, gigantic." To cull the essential from the non essential over a period of one hundred years and present it within the covers of a single volume must have required endless hours of compilation.

This volume is a readable collection of references, case histories and historical summaries. The author commends it particularly to physicians in civil life and returned veteran medical officers to be used in making their own contributions to gynecological literature. It should be very useful since it contains an index of personal names at the end of the volume and the material is divided into chapters according to subject matter. A running bibliography for all references used in the text is carried along at the foot of each page. The paper is a heavy coated one with large print, increasing the convenience of the reader.

*SYNOPSIS OF NEUROPSYCHIATRY.* *By Lowell S. Selling*, SC.M., M.D., PH.D., DR.P.H., Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan; Associate Attending Neuropsychiatrist, Eloise Hospital; Adjunct Attending Neuropsychiatrist, Harper Hospital. *St. Louis: The C. V. Mosby Company.* 1944. 500 pp. $5.00.

Reviewed by Louis H. Gold

It is the author's purpose to present a simplified systematic coverage of neuropsychiatry, to enable the student to get a background of the subject without blocking his memory with detail, to serve as a quick guide for diagnosis and treatment, and to provide a basis for intense review. This purpose is accomplished.

Part I consists of 10 chapters on neurology. They discuss the basic nervous structure and the peripheral nerves, the spinal cord, brain stem, cranial nerves, cerebellum, cerebrum and meninges, autonomic and sympathetic nervous system, muscle syndromes and the convulsive states. Part II has 15 chapters on mental disorders which range widely through the field. The chapter dealing with the parapsychoses tries to draw a line around abnormal behavior which is not psychotic and this distinction will lead to confusion. Each pathologic condition has a paragraph in definition, etiology, pathology, symptomatology, differential diagnosis, military, medicolegal, prognosis and treatment. The last should be more detailed.

The author has undoubtedly been obliged to omit many items in order to make the book compact. He has done well in confining such abundant data to brief chapters. However, added material would have increased the value of this volume. Synopsis of Neuropsychiatry is a worthwhile presentation, should have a wide appeal and has the nucleus of a standard text on the subject.

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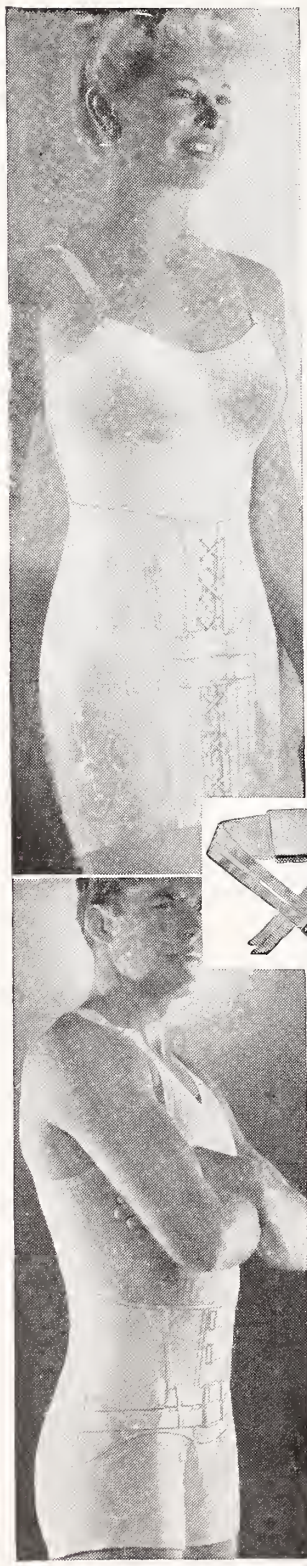
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*A BIBLIOGRAPHY OF VISUAL LITERATURE 1939-1944. Complied by John F. Fulton, Phebe M. Hoff* and *Henrietta T. Perkins.* Prepared by The Committee on Aviation Medicine, Division of Medical Sciences National Research Council Acting for the Committee on Medical Research, Office of Scientific Research and Development, Washington, D. C. *Springfield, Ill.: Charles C. Thomas, Publisher.* 1945. 117 pp. $3.00.

Reviewed by EUGENE M. BLAKE

The value of good vision and the need for the protection of the eyes have long been appreciated but never has this been more true than during the past war. The use of the eyes in flying and navigation and the wide-spread enforcement of black-out conditions have imposed effort upon the eyes of millions of people far beyond those of ordinary civilian needs. This has resulted in a tremendous literature pertaining to the physiology, pathology and psychology of vision. So rapid has been this growth that the British Air Ministry requested assistance in the compilation of a classified bibliography covering all phases of vision on land, in the air and upon the sea, the result of which is the present volume by Fulton, Hoff and Perkins.

Such subjects as color vision, night vision and the visual examinations of military personnel are covered thoroughly, as well as the newer developments in chemotherapy and ocular surgery. Since trachoma is prevalent in many places where the military are sent for duty, a special chapter is devoted to this disease.

As the title of the volume indicates, this is not a text-book nor a year book of abstracts, but it does afford a most useful guide to the recent literature of all aspects of vision, especially since many of the titles are from journals of engineering, electricity, radiology, etc., and from foreign sources not available to most readers. The chapter headings show the range of subjects covered; Anatomy, Physiology and Psychology, Visual Examinations and Testing, Correction of Ocular Defects in Military Personnel, Training of Military Specialists, Ocular Trauma (in Military Services), Goggles and Ocular Protection, Illumination, Visibility.

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### The Physician at Home

Many of you undertook responsibilities approaching the limits of human endurance in order to supply the civilian population with adequate medical care for the duration. The efficiency of civilian war production and the high level of public health are a measure of your effective service in the war effort—which has earned our respect and thanks.

**Our service to the profession was greatly impaired with 14 of our staff in the armed forces. However, the return of these men and the increasing availability of medical supplies and equipment will enable us to render continously improving service from now on. Your patience and co-operation during the war years is sincerely appreciated.**

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The
CONNECTICUT STATE MEDICAL JOURNAL

Vol. IX DECEMBER, 1945 No. 12

# EXPERIENCES AT NAGASAKI, JAPAN

Lt. Comdr. Benedict R. Harris, MC—USNR and
Lt. Comdr. Marvin A. Stevens, MC—USNR

In view of the general interest associated both with the effects of the atomic bombing of Nagasaki and the diseases and disorders encountered among the allied prisoners of war (POW) who had been interned in camps on the island of Kyushu in Japan we thought it worth while to set down our experiences in this area. As medical officers attached to the U. S. Navy Hospital "Haven" (hospital ship), we arrived at Nagasaki Harbor on September 11. We had pulled anchor the day before from Okinawa where we had been acting as a hospital and consulting center for the hundreds of ships of all description comprising a good portion of the Fifth Fleet. The last few hours of our trip had been rendered hazardous by floating mines (strewn by our air force some time before) which had to be detonated by gunfire from our accompanying cruisers and destroyer escorts. Finally we had to stand by until mine-sweepers arrived on the scene to clear our way into Nagasaki Harbor.

One of us (BRH) was a member of a small group which cast off in one of our LCVP's at the harbor entrance to make a preliminary survey of the dock area, particularly to select a suitable site for processing and screening the estimated 10,000 POW's who were to be evacuated from southern Japan via Nagasaki. The dock area was to have been cleared of Japanese by the small guard force which had preceded us, but we were ahead of schedule and the dock was lined with hundreds of Japanese. Because of the terrible destruction which had been wrought on Nagasaki, and since there was some apprehension as to what our reception might be, we went ashore armed, but fortunately our marksmanship was not tested.

Some warehouses were found alongside the dock which seemed suitable for our purpose despite their wrecked state, and the word was sent to our ship via "walki-talkie" to dock alongside the selected area. In the next 36 hours, with the aid of the ship's carpenters, plumbers, steamfitters, and other enlisted personnel, the entire area was cleared, cleaned-up, sprayed thoroughly with DDT to rid the area of millions of flies, lice, and other vermin, and a processing line was set up reminiscent of American belt-line production.

We had arrived at about 1430 Tuesday, September 11, and by 0800 Thursday September 13 train loads of ambulatory POW's and stretcher cases began to roll into the railroad siding alongside the dock. One of us (MAS) was in charge of a surgical rescue team and went to Omuta to investigate Camp No. 17 and Camp No. 25 and make arrangements for their transportation and safe return to the medical screening board headed by BRH at Nagasaki.

After treating a flight officer of a B-29 for multiple fractures (the sole survivor in a crack-up against the Nagasaki mountains while releasing supplies and food at 2,000 feet), one of us (MAS) entrained for Omuta equipped with medical and surgical supplies. Our group consisted of six doctors, six corpsmen, fifteen army personnel, and an interpreter from the University of Southern California who, because his family still resides in Japan, was to be designated only as "Chuck." Chuck was to prove one of the most valuable members of our organization by inducing the Jap officials to be most cooperative.

The 80 mile trip to Omuta took 10 hours and our group arrived in a state of semi-asphyxiation after burrowing through tunnel after tunnel with the car windows open. We divided in the night, half going to Southern Kyusha to investigate conditions in that area.

Camp No. 17 will serve as typical of the prison camps. It was opened on August 10, 1943 with the arrival of 500 American POW's from Philippine

Prison Camp No. 1 at Cabanatuan. The camp was situated on reclaimed land in the vicinity of a coal mine along the edge of a bay, in the provincial manufacturing town of Omuta. The buildings were cheaply constructed Japanese style barracks with ten large rooms opening off a corridor. The rooms were large enough to accommodate comfortably 6 and 4 men in alternate rooms, and the flooring of these rooms consisted of straw matting. These mats were supported by a partial system of slat work holding them about six inches above the ground. At each end of the building there was a pit-type latrine constructed with wooden sides; a concrete urinal in each end of the building drained into an open dirt pit about three feet square. Bathing and laundry facilities were limited to wash stands placed between every other barracks, and a central bath house with hot water in a large concrete tank. There were about 38 barracks buildings and a population of roughly 2,000 POW's. Heating facilities were five small clay pots in each building for the burning of coke. Workers were allowed to have fires for one hour after returning from work in the mines.

Mining was strip-mining, quite hazardous, and our POW's worked at different levels and from temperatures ranging from very hot to freezing. While underground the POW's were handled by Japanese overmen and these civilians were allowed to inflict such beating as they desired, without explanation. Twenty per cent worked in the zinc foundry and had better hours and better treatment.

The camp had Americans from the Philippines, Australians, Dutch, and British who had been taken at Singapore. Practically all prisoners exhibited evidence of the deficiency diseases on arrival at Camp No. 17 from other camps. One group had spent 62 days aboard ship enroute to Japan from Manila. Another group were from the survivors (300) of a detail of 1,600 officers and enlisted men who sailed from the Philippines in December 1944 and underwent severe air attacks in Subic Bay and at Takmo, Taiwan.

The staple item of diet was rice, usually mixed with wheat or Japanese millet (Korian) which has practically no food value. Vegetables supplies to camp ranged from rare beans and potatoes to bamboo sprouts, potato leaves, and vines and scallion tops. Meat was rare. Pears and oranges were received in season. Red Cross food was rarely received and in small amounts.

Dr. Thomas H. Hewlett (Major Medical Corps, U. S. Army) and his staff of six physicians, all POW's, under the command of Col. Robert Schott (Dental Corps) did a marvelous job with limited facilities and medical supplies. Their surgical instruments were made by hand by a Dutch instrument maker. There was no plaster of Paris—wooden splints were fashioned—bamboo traction was applied and bicycle spokes were stolen from Jap bicycles and were used in skeletal traction. No x-ray facilities were available and laboratory facilities were limited. These men became keen clinicians and their records are amazing. Anesthesia was limited to an insufficient amount of procaine tablets which were dissolved for spinal anesthesia. Nearly 200 major operations were performed with better than expected results. The camp had 122 deaths. The Japanese do not believe in a second operation and autopsies were difficult to obtain.

All nationalities had some psychoneurotic problems including thievery and homosexualism. There were five executions by the Japs for offenses such as incorrigible thievery, insubordination, and lack of respect. Ninety-five per cent of the officers and men were at least struck by guards and many were severely beaten with guns, sticks, straps, and boards. One of our orthopedic cases is a loss of both feet from punishment inflicted by having the culprit kneel for hours on a bamboo pile, sitting on his heels. This cut off the circulation and is very painful. Another form of punishment was to strip those in the guard house naked in winter and throw water on them every hour on the hour.

Whereas surgery was indicated in many cases, no immediate surgery was advisable and it was decided to send the POW's including 109 obvious hospital patients to the USS Haven group for screening. There were about 35 bad stretcher cases and these were in very poor condition.

Three Chinese POW camps were discovered containing 3,000 prisoners and having but one Chinese doctor and practically no supplies. Our supplies and those of Camps No. 17 and No. 25 were turned over to them after organizing a semblance of discipline and medical regime for them.

Everything needed was commandeered from the Japanese. B29's were dropping food and supplies at designated areas and all POW's were living off the countryside. Many were overeating. We commandeered Baron Mitsui's club (the Baron owned the mines) and demanded the best of service, viands, wines, and liquors. Geisha entertainment was also offered. Transportation, consisting of all the available trucks and cars in Omuta was used by the

POW's. Samuri swords, Hari Kari daggers, silks, etc., were collected by our men. One Texan and three Chinese beat up FUKUHARA (the brutal Jap guard) necessitating examination and treatment by our rescue team. He is being saved for a criminal of war death.

One thousand POW's and 109 hospital cases were sent from Omuta to Nagasaki by special train in 5 hours on Saturday, September 15. When we stepped off the train at Nagasaki, dirty, tired, and rather bedraggled in appearance, we were mistaken to be returning prisoners and received a royal welcome.

Our screening procedure, roughly, was as follows: POW's, as they stepped off the train, were greeted by "hot" music by an orchestra from the USS Wichitaw. This greeting was psychologically exhilarating as the boys cheered and marked time to the music despite their deplorable condition. They then filed by desks where Army officers obtained data regarding their military status and arranged for messages to be sent to their homes. Following this they went by an ARC area where they received hot coffee and doughnuts donated by, and made aboard, our ship. They then filed by a row of tables where a corps of our nurses filled out short questionnaires pertaining to their previous and present health, more particularly to symptoms and signs of nutritional disturbances, avitaminoses, the diarrheal diseases, malaria, tuberculosis, and the amount of weight loss.

They passed into a covered enclosed area where they undressed completely, and put their belongings into a sea bag which was then thoroughly sprayed with DDT (powder). This bag was to be reclaimed later at the end of the processing line. From here they went to a long hall-like area which had been converted into a shower room. We had constructed two rows, each with ten showers, utilizing the city water from the dock area combined with a steam line from our ship alongside the dock to give warm water. Upon completion of the shower the men were thoroughly sprayed with DDT and then they filed by the medical screening board of 5 doctors where they were questioned and inspected with the aid of the health questionnaires filled out by the nurses. Those who appeared especially weak or malnourished, or who exhibited evidence of severe avitaminosis, or whose history suggested active malaria, dysentery, or tuberculosis were singled out, given slippers and a bath robe and pajamas, and were directed aboard the USS Haven by a physician whose sole duty was to route these men to designated beds on the hospital wards. Approximately 10 per cent had to be hospitalized and the remainder were considered well enough despite weight loss and moderate avitaminosis to go directly to waiting aircraft carriers, cruisers, destroyers for evacuation to Okinawa and then to their ultimate destination. These men were all thoroughly deloused by spraying and powdering with DDT, given new outfits or reclaimed their own deloused clothing. New outfits were complete from underwear to shoes, and were the first some POW's had had in three years. The very seriously ill patients were not put through the shower line. They were taken directly to another area where their clothes were removed, and thrown away. They were then sprayed with DDT and taken directly aboard the "Haven." It had been planned to process and screen about 1,000 men a day, and this scehdule was carried out as per the original plan over a 10 day period.

Inspection of the POW's as they filed by, supplemented by brief questioning of each man, clearly indicated the unspeakably horrible and degrading conditions under which they had existed for two to three and one half years. Hard work in ship yards and mines, ragged clothes unsuited for the climatic and other conditions under which they worked, a pittance of rice and soup for their three meals, inadequate bathing facilities, vermin-infested living and sleeping conditions, together with brutality of the most vicious type had contributed to make their lot extremely unhappy and difficult of survival.

Many had been cremated following death from deficiency diseases complicated by pneumonia, from dysentery, malnutrition, and inadequate supplies or medical care. Even though the Red Cross had sent sufficient medical supplies the Japs had refused to give out adequate amounts of medicines such as sulfa drugs, vitamins, and anesthetics. Many of the prisoners going through the line were seen to have angulated healed fractures of the long bones of the forearms, the results of beatings by the guards.

Actually, practically every POW exhibited some degree of malnutrition and beri beri and other evidence of deficiency disease. The cases admitted were only the more serious of those seen. It must also be remembered that all of these camps had had food and vitamins dropped by plane for a period of one to three weeks and we saw these men in much better condition than they had been on August 15.

Aboard ship the men were put to bed, given frequent small feedings of a high-calory, easily-digest-

ible diet rich in starches and proteins. They received high potency vitamins three times daily supplemented by thiamin chloride 50 mg intra-muscularly and 5 mg t.i.d. by mouth daily. Selected cases were given ascorbic acid and nicotinic acid. Intra-venous thiamine chloride, in 100 mg doses were given to those cases of beri beri which exhibited marked dyspnea. Marked diuresis promptly ensued, and weight loss of 8 to 15 pounds from loss of fluid in 24 hours was not uncommon. All patients received an x-ray of the chest, the blood was examined routinely for hemoglobin, hematocrit, and total proteins, urine examination, and examination of the stools for ova and parasites was also done, the latter only when indicated. On the surgical wards particular attention was paid to the inclusion of large doses of vitamin C and of nicotinic acid as experience indicated that these patients bleed easily and freely after even minor operative procedures.

A rough breakdown of the cases admitted to the "Haven" in the first seven days gives one a better idea of the disorders and diseases encountered.

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|---|---|
| Beri Beri (moderately severe or severe) | 312 |
| Pellagra | 18 |
| Malnutrition (loss of 50 to 60 pounds) | 64 |
| Dysentery (blood or mucous in stools) | 48 |
| Tuberculosis (active) | 38 |
| Fever of unknown origin | 24 |
| Infections (including abscess, furuncles) | 24 |
| Burns (atomic bomb) | 19 |
| Fractures (unhealed) | 15 |
| Hookworm (corroborated) | 21 |
| Malaria (recent chills) | 12 |
| Jaundice (infectious) | 8 |
| Osteomyelitis | 4 |
| Bronchitis (with fever) | 18 |
| Pneumonia (atypical) | 9 |
| Arthritis | 8 |
| Cellulitis | 7 |
| Psychosis | 2 |
| Miscellaneous (including one leprosy) | 65 |
| Total (of approx. 7,000 POW's) | 716 |

We have been impressed by several features: First of all the small incidence of psychosis; secondly the great incidence of the avitaminoses, particularly of both the dry and wet forms of beri beri, with the wet type predominating; thirdly the ability of these POW's to carry on despite weight loss of 50 to 60 pounds; fourth, the prompt response to adequate therapy. Dyspnea and tachycardia have been striking in the beri beri group, and the dyspnea seems to disappear early while the tachycardia persists. In a week it has been possible to discharge almost 25 per cent of the patients for further evacuation in transport ships. It is also worthy of comment that many of the POW's developed massive edema shortly after eating heavily of the rations dropped by plane, some of them becoming edematous for the first time. It is presumed that diminished absorption due to acute diarrhea caused by the inability of the gastro-intestinal tract to accept the marked increase in amount of food plus fluid retention caused by the increased salt intake, combined to be responsible for this phenomenon. Much work remains to be done with these patients, and further report will be made when it is possible to evaluate clearly their exact medical status and response to appropriate therapy.

Surgically all patients are retarded by malnutrition, many are poor surgical risks, are prone to infection, all severe orthopedic cases have multiple pressure sores, and all bleed freely and clot poorly following incision. Severe cases need daily blood transfusions and careful nurse care. Elective cases must be carefully evaluated before operative procedures are undertaken.

### THE ATOMIC BOMB

The effects of the atomic bomb as we saw it may be divided into (a) physical destruction and (b) diseases, disorders, and injuries. During the course of our stay in Nagasaki we have had the opportunity of going through the devastated area and its environs, and of visiting a large school house which has been converted into a temporary civilian hospital. A few words best describe the physical effects of the bomb—unbelievable, awful, complete destruction and disintegration. We had seen the tremendous destruction caused by bombing and heavy gunfire in the destroyed city of Naha on Okinawa, and one of us (MAS) the destruction in the ETO, but the total destruction over so wide an area such as is present in Nagasaki from one bomb simply staggers the imagination. The center of the bombed area lies between a huge steel works, an ordnance factory, and the combined medical school and hospital. A few twisted, seared steel girders remain as mute evidence of the destructive force of the atomic bomb. The medical school and hospital situated on a hillside well above the surrounding area was completely gutted by heat and fire from the bomb, and a Japanese doctor informed us (in German) that the only survivors of the medical school personnel were those who were fortunate to be out of town that day. Everyone else was "extinguished." For miles around this area there is complete destruction and obliteration. Here and there a factory chimney

r a single concrete wall stands pathetically alone. Shinto shrine, with its two uprights and cross bars ses up in the center of the devastated area, curious- untouched. The area has the appearance of a huge ums clearance project where the buildings have een razed, the ground leveled by bulldozers, and ıe wreckage removed but we know that here there as simply been disintegration. One has no difficulty finding charred skulls or fragments of long bones the rubble. In the outskirts of the city there is arcely a house which remains intact—roof and de walls are caved in, windows are devoid of glass, ıd the stench of decaying flesh and spoilage is ersistently nauseating. The Japs move about de- ated, bewildered, sullenly and silently making dividual attempts to build flimsy shelter with the nited material at their disposal.

At the civilian hospital in the converted school ouse the scene was most pitiful. The patients lie on raw mats on the floor so close to each other that ıe has difficulty walking between them. Their milies move right in with them, doing what they n to feed them and to help the few Japanese nurses caring for the sick and dying. Vomitus, feces, ench, and millions of flies revolt even war hardened octors. We have cut down the flies by the liberal e of DDT. About seventeen doctors and thirty urses are doing what they can to help these victims. heir supplies are meagre and inadequate.

From our observation and from conversation with e Japanese doctors it is obvious that most of the sualties were immediate—from blast and the rrific heat engendered by the atomic bomb. Those ho were found alive had burns of the "flash" type, iefly first and second degree burns, extensive but t deep. Most of the cases we saw represented diation effects at the time of the bombing, namely pecia, bone-marrow depression with reduction of d blood cell count to between 2-3 million, leuco- nia as low as 500, the granulocytes being par- ularly affected, bleeding into the skin, and from the mouth and intestinal tract, lethargy, and profound prostration and weakness. There had been several thousand deaths from this late radiation effect but many of the patients were beginning to show signs of recovery. As far as we were able to determine, there is not enough deposit of radio-active material in the area at present to produce deleterious radiation effects at this time and it has been determined that all the cases received their over radiation at the time of the actual bombing.



Nagasaki, September 15, 1945

Building in background was medical school and hospital. Shinto shrine is one described. Photograph shows surrounding devastation just as it appeared after bombing, nothing has been carted away. This was a heavily populated area before the bombing.

In conclusion we may state that this has been a most interesting experience. The horrors of war and especially of the destructive and disabling force of atomic bombing, even in its infancy of application in the science of war, has been so impressed upon us that we add our feeble voice to the demand that those terrific elements of destruction be controlled, by force if necessary, by only peace loving peoples, else we in turn destroy ourselves.

# THE 39TH GENERAL HOSPITAL

Lt. Col. James C. Fox, Jr., MC—AUS, *Hartford*

The Author. *Formerly Unit Director and Chief of the Medical Service*

The first meeting of doctors to volunteer for the "Yale Unit" took place on August 1, 1940, shortly after France had fallen, when the aerial assault on England was about to begin and the cause of freedom seemed so desperate. Yale had sponsored the 39th Mobile Surgical Hospital in the first World War and had recently agreed with the War Department to organize a General Hospital also to be known as the 39th. Medical officers and nurses were commissioned during the following year and a half. After Pearl Harbor filling of the table of organization went on apace, including the selection of a Chaplain, mess officer, physiotherapist, dietitian and 20 enlisted reservists. Friends of the Unit gave generously to a fund for a small medical library and later this was to provide certain surgical instruments, laboratory and photographic equipment, and dental supplies which were not standard items furnished by the Army. After many rumors and two semi-official "alerts," the order finally came for mobilization at Camp Edwards on July 15, 1942.

The 57th General Hospital, composed of 8 officers and 500 enlisted men under the command of Colonel Ottis L. Graham had been in training for three months and constituted the parent organization. During the following 10 week period of training a large proportion of the personnel were on duty at the station hospital. The fine points of close order drill, chemical warfare and military custom and law were learned. After rigorous calisthenics at dawn the order to "fall out" was sometimes interpreted as "fall down." A joint review with the neighboring 212th Field Artillery took place September 3 and the subsequent bivouac at which the 39th was a guest turned out to be a memorable occasion. The outfit underwent its first painful adjustment when it became necessary to declare 8 medical officers and 1 dental officer surplus in order to conform to a change in the table of organization. This was only the beginning of constant readjustment in personnel. Immediately afterward, to everyone's amazemei there arrived 6 medical officers in a newly creat replacement pool.

The transcontinental trip which started on Oct ber 1, took five days. The five minute incognito st in the New Haven Railroad Station instilled stran feelings in all. Shortly after arriving at Camp Stor man in California training schedules were resume Ingenuity of various members soon manifested self in the planning of military "missions" to S Francisco, some 30 miles distant. Nineteen nur were transferred from the Station Hospital to co plete the total complement of 120. Additional offic strength at this time was as follows: Medical—4 Medical Administrative—8, Dental—6, Quarterm ter—2, Sanitary—2, Chaplain—2, Veterinary—1, W rant Officer—1. There were also 3 dietitians, 2 phy cal therapists, 5 Red Cross workers, and 497 listed men. The smooth Pacific crossing in the goo ship Tjisadane consumed 19 days. The discomf of crowded quarters and an uncertain diet were some extent offset by the excitement of travelli in convoy. Safe arrival in the beautiful harbor Auckland occurred on Sunday afternoon, Nove ber 22, to the strains of the "Beer Barrel Poll played by a New Zealand military band.

The outfit was "put out to pasture" in a N Zealand camp and neighboring agricultural coll at Paerata, some 25 miles south of Auckland. Liv conditions were fairly rugged including the fi type ration. It was customary for the nurses to l beneath their beds at night to make certain tha stray rodent had not taken refuge thereunder. Sh ly after arrival it was learned that the U. S. Na Mobile Hospitals—No. 4 in Auckland and No. 6 Wellington—were having some difficulty in handl a large number of casualties from the Guadalca campaign. Consequently, the services of part of personnel were offered and accepted for the n two months.

The dead line for opening the hospital had b set by higher command as February 7, 1943, and this day 164 Army patients were actually tra ferred from the Naval hospital. Hundreds of carp

ters, plumbers, and painters were still at work on the unfinished buildings and the staff were still eating out of their mess kits while sitting on lumber piles scattered about the grounds. The hospital reached its original authorized capacity of 1,305 in April but the demand for beds by the increasing number of evacuees from the forward area soon exceeded this figure. Therefore, it became necessary for a while to house convalescents in a U. S. Army camp on the public domain of Auckland three miles distant from the hospital. This need for expansion had been anticipated by the erection of 14 additional wards to be utilized as a convalescent section. In addition to its own mess hall and Army post exchange this section had a gymnasium. The total number of beds was thus increased to 1,921 but on October 8, 1943, the hospital actually had under its jurisdiction 2,154 patients.

In its final form the institution consisted of 115 buildings situated in Campbell Park, a former golf course in the southern environs of Auckland. The buildings were of stucco with decorative red tile roofs. In general, the plan conformed to the standard Army cantonment type of construction but the central facilities such as the operating suite, laboratory, and x-ray building were originally built large enough to accommodate the maximum load of patients. The plaster room was conveniently located at the entrance of the x-ray department. Other features were a screened isolation ward with proper facilities for individual units and sterilization of dishes, a closed psychiatric ward, adequate space for physical and occupational therapy, a conference room, a small library, a photographic dark room and a nurses' laundry.

New Zealand has a fairly even climate with temperature fluctuating between 40 and 80 degrees and, of course, reversal of the seasons. Much of the vegetation remains green throughout the year. Immediately behind the hospital arose "one tree hill." Many a patient climbed this at sunset to test out his returning strength and also to view the beautiful harbor of Auckland which stretched out far to the north, east and south. The formal entrance to the grounds, the broad vista of lawns, the stately trees, and abundance of flowers produced a scene which the members of the unit will always fondly recall.

The turnover of patients during 1943 was rapid. The greatest number of admissions for any one day was 922 on September 23 while the largest number of discharges was 857 on October 12. Such a mass movement necessitated the employment of special procedures. The admitting officer and his assistant frequently boarded the incoming hospital ship with the pilot before it entered the harbor. He carried with him assorted tags corresponding to available free beds. Hurried appraisal of each patient's medical status was made and the proper tag was attached to the patient's blouse. As the patients were carried off the ship by litter or came down the gang plank they were directed to waiting ambulances according to ward assignment. Each group was then delivered to the back of the designated ward. Clerks from the admitting office, assisted by the charge nurse, completed the necessary clerical work at the bedside. By this method it was found possible to admit hundreds of patients within the course of an hour.

During the 20 months operations of the hospital in New Zealand over 24,000 patients were handled. Of this number, approximately 25 per cent were admitted with the diagnosis of malaria and an equal number with psychiatric disorders, chiefly classified as psychoneuroses of the anxiety type. The number of battle casualties fluctuated widely depending on the military situation in the forward area. The majority of patients came by water transport. They were mainly from the Americal, 25th, 37th, and 43rd divisions who were engaged in the Guadalcanal, New Georgia and Bogainville campaigns. In November 1943, the 25th division arrived in New Zealand for a period of rest and rehabilitation. This was followed in February 1944 by the 43rd division. The 39th General served as a station hospital for these troops. The 13th Air Force also used New Zealand as a rest area and many of its members were treated in the hospital. In passing it should be added that not enough credit has been given to the heroic exploits of this force during the early days of the Pacific campaign which laid the ground work for the great forward surge which was to come later.

Tertian malaria played the major role throughout practically the entire period. The troops had been heavily seeded during the early Solomon campaigns and the relapse rate remained high. On occasion as many as 20 patients developed a chill during the night, keeping the Medical O.D. on the run. Estivo-autumnal malaria was relatively rare. In this connection there is considerable experimental evidence—both clinical and laboratory—that atabrine, if given in adequate dosage, may actually eradicate infection due to plas. falciparum and thus prevent a clinical attack. After an initial trial of various combinations of atabrine, quinine and plasmochin, treatment of

the uncomplicated disease finally was simplified to a weekly regime totaling 2.8 gms of atabrine, with initial booster dosage. All personnel who were returning to the forward area received the suppressive dose of one tablet (0.1 gms) per day.

A continual program of clinical correlation and laboratory study of malaria was conducted. Most important was determination of the atabrine content of the blood and its protective value following various dosage. This investigation was instigated by Colonel Baker, medical consultant to the South Pacific Command. Two of his former colleagues from the 18th General Hospital (Johns Hopkins Unit located at Fiji), Lt. Colonel Shaffer and Lt. Lewis were attached to the 39th General to collaborate in the experimental work. This involved a photometric technique based on the fluorescent property of the drug.

An immunological study was also conducted by Major Gray Carter. One hundred volunteers from one division were kept in residence for an extended period of time. After an attack of tertian malaria twenty-five served as controls and were treated with atabrine in the routine fashion referred to above. The remaining members of the group were divided into three sections of 25 each, depending on whether they had (a) no previous attack (b) one previous attack (c) two or more previous attacks. The entire experimental group were allowed to run a natural clinical course consisting, on the average, of 10-12 rigors with careful watch on the blood count and general physical condition. They were then treated with atabrine in the standard fashion and the subsequent relapse rate of the experimental group was compared with that of the control group. Repeated checks were made on blood atabrine levels during the course of the experiment. Observations at the end of 6 months indicated a measurable degree of protection afforded by allowing the disease to run an abbrievated course. Much of clinical interest was also learned from watching the natural course of the disease and no ill affects resulted.

The rediscovery of cutaneous diphtheria, which had apparently escaped clinical attention since the last war, was made by Major Averill Liebow, chief of the laboratory. A nurse, who was caring for a patient with a "tropical ulcer," developed pharyngeal diphtheria. Subsequently corynebacterium diphtheriae with the typical morpthology and fermentation reaction of the Klebs-Löffler bacillus was demonstrated in various types of open skin lesions in addition to the typical "punched out" ulcer. Further proof of their virulence was obtained by the controlled intra-cutaneous method of Frazer and Weld. The diphtheria bacillus was usually found in conjunction with staphylococci, streptococci, and non virulent diphtheroids, although it was frequently the predominating organism. In the majority of cases the Schick test was negative. At first only the Schick positive cases were given antitoxin; later all patients with positive cultures were treated. This seemed to promote slight if any healing of the lesions. However, it was believed that antitoxin might help to forestall the development of peripheral neuritis which had been observed in a fair number of cases. The neuritis differs from that following pharyngeal diphtheria in that the palate and pupils are rarely involved. Also the neuritic manifestations are in general much less marked, tending to be confined to the lower limbs and consisting of minimal distal sensory impairment, mild muscle weakness and diminution of the deep reflexes. The total protein in the spinal fluid is likely to be elevated above 100 mg. per cent during the early stage.

Early in 1943 it was discovered that hook worm *infestation* was widespread among troops who had lived under field conditions in the South Pacific Islands. For example, screening of the first 1,000 officers and enlisted men admitted from one division between November 8 and December 3, 1943, revealed 221 (22 per cent) with eosinophilia of 8 per cent or above. Hook worm ova were also demonstrated in the stools of 93 (9 per cent) of these patients. In one of the infantry regiments the percentage of infestation ran as high as 40 per cent. However, the actual incidence of hook worm *disease* was certainly not enough to reduce the effectiveness of combat troops. In a detailed study of 39 cases only 3 were found to have an anemia of less than 4,000,000 R.B.C. per cu. num. Eighteen (46 per cent) of these patients were considered cured by one treatment of tetrachlorethylene (series of 5 negative stool examinations). Another 10 (28 per cent) required 2 courses of treatment. Six patients (15 per cent) proved refractory to as many as 7 treatments.

Various other studies were carried out by the staff such as the proper time to change casts in the handling of compound fractures being treated by the Orr method, repair of arteriovenous aneurysms, the effect of x-radiation on extensive granulating wounds, the proper surgical approach in handling of pilonidal sinus, suture of peripheral nerves and effect of blast upon auditory function.

During the 4 month period from July to October 1943, there were admitted a large number of severe anxiety and hysterical states, precipitated by combat experiences. Thorough case studies revealed that in the majority combat had merely aggravated a deep seated emotional instability existing prior to entering the service. However, in others the strain proved too great for what had apparently been a normal stable personality. Many soldiers who had managed to "stick it out" throughout the campaign, often performing heroicly, became nervous as soon as they relaxed in the secure rear area. This is the group that is likely to develop depressive symptoms associated with gastro intestinal disorders. It was soon learned that the course and ultimate outcome in such a case is harmed rather than benefitted by lengthy clinical studies, multiple time consuming laboratory procedures, special diets and elaborate programs of physical and occupational therapy. It is vital to return these patients to some type of duty as soon as possible although very few can be assigned to tactical units. A fair number can be salvaged for the service forces not in the combat area. Of course there are many individuals whose personality defects peculiarly incapacitate them for military life and discipline. The old adage that "the Army will make a man out of you" is unfortunately rarely true.

Skin disease was a widely disabling factor. As simple an affair as acne on the back may incapacitate a soldier for carrying a pack. Tinea was the most prevalent, aggravated by the heat and moisture of the tropics. The large number with dermatophytid of the hands proved very discouraging. These were the patients who tended to relapse even under favorable conditions provided by the temperate climate of New Zealand. Some previously resistant lesions cleared up with rest in bed and simple exposure to the air and sun. Over treatment with medicaments such as high concentration of salicylic acid, strong mercurial preparations and particularly sulfonamide ointment had often incited a regional eczematous or even a generalized dermatitis.

The argument will wax long after this war, as it did after the last one, whether a balanced hospital unit, staffed with qualified specialists, should be kept together to perform all types of definitive care or whether its personnel should be dispersed to fill the needs of other units in the same theatre. The 39th General Hospital, similar to all others sponsored by universities, suffered a gradual loss of personnel. After two years overseas, of the original 57 medical officers appointed prior in mobilization, 31 (54 per cent) remained. Seventy per cent of the 44 actually starting overseas were still with the organization. During this period the unit still had 80 (66 per cent) of the 120 nurses who had left the states. Space does not permit telling of the exploits and achievements of various members who have served elsewhere in the Pacific area or who have travelled to far distant climes. The nurses were always eager to volunteer for any mission "up in the Islands." In fact the entire nursing complement of two station hospitals on Guadalcanal were filled in this manner.

Following the sudden illness of Colonel Graham the command was taken over by Colonel Don Longfellow who arrived a month later on May 14, 1943. Special mention must be made of Captain Orrin Crankshaw who departed for Guadalcanal in December of 1942. Later it was his unusual privilege to serve with distinction in the European theatre as well, where he was killed in action. The 39th mourns the loss of this gallant friend.

Toward the close of 1944, as the Pacific war swept ever northwestward, the patient population of the hospital had dwindled to a few hundred. Orders had already come to pack and undergo a training program for the more rugged life which lay ahead. The destination proved to be Saipan but this is a different chapter which requires another telling.

# PNEUMONIA AND EMPYEMA DUE TO BETA HEMOLYTIC STREPTOCOCCUS

Lt. Comdr. Ralph E. Durkee, Jr., USPHS, *Hartford*

The Author. *Chief of Medical Service, U.S.P.H.S. Hospital, Sheepshead Bay, Brooklyn, N. Y.*

As in other general hospitals in this country that serve military personnel, we have been impressed by the very high incidence of beta hemolytic streptococcus infections during the past three years. Scarlet fever has predominated, but there has also been a large number of streptococcus infections of various forms without the characteristic rash. Pneumonia with pleurisy due to hemolytic streptococcus was rare and sporadic during the first two years, but for some obscure reason it reached epidemic proportions during the winter of 1944-45. Apparently this is the same disease that proved so fatal during World War I when the beta hemolytic streptococcus acted as a secondary invader following influenza.[1]

Descriptions in the literature of the 1918 epidemic[1,2,3] indicate that more than 60 per cent of the cases were characterized by a massive, thin, purulent pleural effusion which appeared early in the course of the disease during the most acute phase of the pneumonia. The first treatment used was rib-resection and open drainage of the pleural cavity at the height of the disease, a procedure which led to a very high mortality, figures varying from 45 per cent to 85 per cent with an average of about 60 per cent.[3] Later in the epidemic, closed thoractomy was used with some lowering of the mortality, but this treatment also proved to be far from satisfactory, because of the difficulty in keeping the thoractomy airtight and because of the frequency of persistent infection in the thoracic cavity that required open drainage. The treatment at the end of the epidemic which led to the lowest mortality was repeated thoracentesis during the height of the disease, followed by open thoractomy late in the course after the pleural exudate had thickened and the mediastinum had become stabilized by adhesions. Eventually open thoractomy was practically always necessary because of persistent infection in the thoracic cavity in spite of any means of closed drainage that was used. The mortality rate repoted from this last method of treatment was 20 to 30 per cent. Numerous authors, including Heuer of New York,[3] on reviewing these cases after the war, were reluctant to attribute the entire decrease in mortality rate to improved treatment; they felt that it was partially due to a decrease in the virulence of the disease towards the end of the epidemic. The fact remains, however, that even at best the mortality was high and open drainage of the chest with long convalescence was almost always required.

## I—CLINICAL PICTURE

The disease, as we have seen it, has not been preceded by influenza but has come on in most instances without any antecedent respiratory infection. In the typical case the onset was sudden with the constitutional manifestations far in excess of the physical findings in the early stage. Immediately the patient became dangerously ill with hyperpyrexia, cyanosis, dyspnea, profuse sweating, and sometimes circulatory collapse. X-ray of the chest during the first twenty-four hours sometimes showed a small patch of increased density in one of the lung fields, or slight elevation of one diaphragm. Frequently the film was entirely negative. The patient soon experienced severe pleuritic pain in the side of the chest involved and within forty-eight hours a massive pleural effusion developed so that by x-ray one whole lung field was largely obscured by a dense opacity. It was during this developmental stage that the systemic symptoms were at their height; in fact, the one death that occurred in our series of 120 cases came within the first few hours after the onset, apparently from overwhelming infection, before the pleural effusion had reached an extent which would warrant thoracentesis. In some cases the onset of pleurisy was so early that no stage of pure pneumonia could be detected. The patient was stricken with severe pleuritic pain and by the time he came under observation the rapidly developing pleural effusion had already obscured the lung field. During

the height of the disease, which was usually the first four to six days, the temperature ranged between 104° to 107°F., but as the systemic manifestations began to subside, the fever tapered off very gradually and it usually remained between 100°F. and 102°F. for two or three weeks while the pleuritic process was undergoing resolution. This prolonged course occurred in spite of the vigorous use of penicillin and was in direct contrast to pneumococcus pneumonia where the temperature drops sharply to normal within twenty-four to forty-eight hours after the institution of such therapy.

### II—VARIATIONS IN THE CLINICAL PICTURE

The majority of our cases of hemolytic streptococcus pneumonia (68 per cent) were characterized as outlined above by the almost simultaneous inflammatory reaction of lung and pleura and by a massive pleural effusion developing during the height of the disease. Worthy of note, however, are certain variations from this typical picture. In numerous instances there was pneumonia with severe pleuritic reaction and persistent pain but without effusion. These patients were left with residual pleural thickening and adhesions which were less extensive than in the cases with effusion. There were a few cases of upper lobe involvement without apparent pleurisy, which yielded almost pure culture of hemolytic streptococcus in the sputum. One of these suffered from a toxic psychosis of five days' duration followed by complete recovery. In one interesting case there developed two loculated areas of pyopneumothorax which apparently resulted from extension of the infectious process into the pleural space with local rupture of the visceral pleura. The typical thin greenish exudate was aspirated from one of these pockets and recovery was eventually complete following intramuscular penicillin therapy. Comparison with sporadic cases of hemolytic streptococcus pneumonia and with cases observed in civilian life, most of which appear to be secondary to a preceding respiratory infection, would seem to indicate that the desperate illness which characterized our series results only when a given strain of the organism obtains unusual virulence. In support of this contention it was noted in our series that the highest proportion of cases with empyema occurred at the peak of incidence of the disease, whereas the highest proportion of cases without obvious pleural involvement occurred early and late in the epidemic.

### III—LABORATORY FINDINGS

The beta hemolytic streptococcus was isolated from the sputum in every case in this series. Numerous other cases with similar clinical picture were not included because of our inability to obtain bacteriological proof of the nature of the infection. Unfortunately, facilities did not permit the routine typing of the organisms during this epidemic but samplings of the organisms obtained in this hospital through the spring of 1945 yielded types 3, 6, 12, 17, 24, 29 and 30. Initial blood cultures, positive for beta hemolytic streptococcus, were obtained in 9 per cent of the cases, although this figure was probably lowered slightly by the fact that a small number of patients received specific therapy before they were admitted to the hospital.

The white blood cell count was markedly elevated in the early stage of the disease, frequently above 40,000/cu.mm., and occasionally above 60,000/cu. mm. with a very high proportion of polymorphonuclear leucocytes. The lowest initial white count in this series was 11,000 and the highest was 68,000. The erythrocyte sedimentation rate was also markedly elevated, frequently above 100 mm/hr. during the acute stage. The lowest initial E.S.R. was 38 and the highest was 127 mm/hr. The E.S.R. was also a useful guide during convalescence as it remained elevated during the persistence of inflammation in the pleura even after the temperature and white blood count had returned to normal. The hemoglobin and red cell count were affected only slightly in most cases, and no instances of severe anemia were noted.

The pleural fluid, which was remarkably uniform from one case to another, was thin and cloudy with a greenish tinge. The cell count varied from 10,000 to 25,000/cu.mm. and was made up almost entirely of polymorphonuclear leucocytes. The fluid had a specific gravity of 1.018 to 1.020 and was thus definitely an exudate. A culture positive for beta hemolytic streptococcus was obtained from the pleural fluid in a goodly portion of cases (15 per cent) when thoracentesis was done early, but cultures of subsequent aspirations were uniformly negative. It is of interest, however, that streptococci could occasionally be seen on smear when they could not be cultured, presumably because of the inhibiting effect of penicillin. In spite of the high protein content of the pleural fluid and the large amount of fluid produced in some cases (10 aspira-

tions of 1000 cc. each in one), the plasma proteins were not reduced.

IV—THORACENTESIS

One of the most controversial points regarding the management of the acute empyema is whether, when, and how to remove the pleural fluid. We believe that the removal of fluid without the production of a pneumothorax is frequently indicated and that it is often a lifesaving measure during the acute stage. Some of the severe cases rapidly develop a massive effusion which entirely fills one pleural cavity and displaces the mediastinal contents to the other side of the chest, resulting in extreme mechanical embarrassment to respiration. This difficulty associated with the acute toxemia which is always present in the acute stage could easily lead to a fatality. Removal of sufficient fluid to allow the mediastinum to return to its normal position always results in relief of the respiratory distress and is frequently followed by a marked improvement in the general condition. Thus the relief of the acute mechanical embarrassment of the early stage is the first and foremost indication for the removal of pleural fluid; but since there is a strong tendency for the fluid to be replaced at this time, the improvement may not be permanent. Therefore, we believe that aspiration in the first few days should be limited to those acute cases in need of immediate relief.

Later in the course of the disease, when the initial acute phase has passed, there is frequently a stationary stage in which the temperature fluctuates between 100° and 102°F. Removal of a substantial amount of fluid at this time usually leads to a rapid improvement which is permanent because the fluid shows less tendency to return.

Many times it is noted after the temperature has return to normal that the E.S.R. remains elevated and that the patient has a persistent tachycardia and a tendency to profuse sweating, signs which are frequently indicative of residual fluid in the chest. There seems to be a rather strong tendency for the persistence of pockets of fluid over a remarkably long period of time, whereas successful location and aspiration of the fluid leads to a much more rapid recovery. The location of these pockets has been accomplished in several of our cases with the aid of the fluoroscope. In general, then, it is agreed that any appreciable amount of exudate persisting after the initial stage of the illness should be removed, not only to improve the general condition of the patient but to minimize the residual thickening of the pleura.

We have used simple thoracentesis successfully for the removal of the pleural fluid in all except one case. In this instance after ten thoracenteses and three intrapleural instillations of penicillin, a closed thoracotomy was done because the residual effusion, though sterile, was too thick to pass through the aspirating needle.

The pleuritic process invariably leads to adhesion of the parietal and diaphragmatic pleurae with elimination of the costophrenic angle, a fact which should be taken into account when deciding upon the location for thoracentesis. Thus the needle should be inserted somewhat higher than for the removal of a transudate and care must be exercised to prevent the influx of air into the pleural cavity.

As noted previously, thoracentesis was used in some of the cases in World War I, but the pleural fluid always remained infected and an open thoracotomy eventually had to be done. We now have in penicillin a means of sterilizing the pleural cavity and the immune and reparative processes of the body are able to dispose of the sterilized effusion which remains after simple aspiration.

Certain dangers and disadvantages to thoracentesis have been noted by various authors. We are warned that rapid removal of pleural fluid may be followed by circulatory collapse, pulmonary edema, or sudden death.[4] None of these unfortunate accidents occurred in any of our cases. In order to avoid a sudden shift of the mediastinal structures with dangerous symptoms, we aspirated slowly and limited the volume of any one aspiration to 1000 cc. If the removal of more fluid were indicated, we repeated the procedure twenty-four hours later. With these precautions we encountered no untoward symptoms excepting transient paroxysms of cough near the end of the procedure.

V—SPECIFIC THERAPY

Although the comparative virulence of the organisms with those of 1918 and the outcome of severe cases without specific treatment remain unknown, the difference in mortality from this disease now as compared to World War I must be attributed primarily to penicillin which was used in all severe cases, because it is much more effective against the hemolytic streptococcus than the sulfonamides, and because its administration to a very sick patient is easier and less dangerous. Following an initial intra-

venous dose, penicillin was given intramuscularly every three hours in such amounts that the total doses varied from 100,000 to 400,000 units per 24 hours. We observed that a minimal dose of 200,000 units per 24 hours was required for optimal effect in this disease, and in a few cases which failed to do well on this dose, an increase to 400,000 units per 24 hours brought forth a much better response.

The reaction of this disease to either penicillin or sulfonamide therapy is in no way similar to the response of pneumococcus pneumonia. In the latter case the temperature drops rapidly to normal within 48 hours and the medication may be discontinued after 4 or 5 days. In contrast, these cases of streptococcal pneumonia developed a massive empyema in the face of very heavy penicillin dosage and the penicillin had to be continued for from two to four weeks. There was no sharp drop in temperature as is seen in the pneumococcal type. The fever reached its peak during the first two or three days and then subsided gradually over the subsequent two to four weeks. After the patient had been afebrile for three or four days the penicilin dosage was halved, and in another three or four days it was stopped. With this conservative procedure, flare-up of the disease process following withdrawal of the drug was rare.

It has been recommended by many that penicillin be injected directly into the pleural cavity at the time of thoracentesis. This, no doubt, is a very effective procedure as shown by Tillett, Gambier, and McCormack[5] in pneumococcus empyema, where the exudate is thick and is walled off by fibrin. In the acute empyema of streptococcal origin, however, we know that penicillin given intramuscularly penetrates the thin pleural fluid in adequate concentration (0.3 to 0.7 units/cc. in our cases) and that the fluid is practically always sterile upon culture after 24 hours of treatment. Ten of our cases were treated with intrapleural penicillin (50,000 units in 50 cc. saline on one to three occasions) and no additional benefit was noted from this procedure. Furthermore, we know that penicilin acts as an irritant in the spinal canal and when given intrapleurally it may add to the pleuritis and pleural thickening which inevitably result from the disease.

During the early part of the epidemic penicillin and a sulfonamide were used concomitantly in treatment, but numerous reports concerning the treatment of pneumococcus pneumonia and various streptococcal infections seemed to indicate that penicillin alone is just as effective. Furthermore, this simplifies the treatment considerably because these patients are so sick in the acute stage that it is almost impossible to maintain the dilute and alkaline urine that is necessary for protection against kidney damage during sulfadiazine therapy. It has therefore become our custom to use penicillin without a sulfonamide unless there is some specific indication for the latter, and results have been equally as good under this program. Oxygen and parenteral fluids are necessary as in any severe pneumonia.

### VI—COMPLICATIONS

One of the earliest complications encountered in the course of the disease was circulatory collapse which occurred in several instances and was characterized by a dangerous drop in blood pressure, pallor, profuse sweating, thready pulse, etc. Our experience was in agreement with recent reports to the effect that large amounts of plasma are effective in the circulatory collapse of infectious disease,[6] as the condition responded well in each instance. The severe nature of the illness, the loss of pleural fluid, and the prolonged course resulted in losses of weight of from 25 to 50 pounds in the most acute cases. Three of the sickest patients developed severe attacks of urticaria late in the disease, probably related to prolonged penicillin therapy. In each instance the hives were extremely persistent over a course of about one week in spite of all the usual methods of therapy, and were associated with fever and with swollen, painful joints.

All the cases with an associated pleurisy, and especially those with empyema, were left with pleural thickening after the subsidence of the acute illness. In proportion to this pleural reaction there was a tendency to the development of dorsal scoliosis with concavity toward the side of involvement. We mentioned previously that the E.S.R. usually remained elevated for several weeks as the inflammatory pleural reaction was gradually subsiding, but even after the E.S.R. had returned to normal and the patients were ready to leave the hospital, some pleural thickening remained. Before a patient was released to duty, a long convalescence, sometimes amounting to several months, was needed, and was utilized in graduated activities with special attention to breathing exercises and to postural training for the correction of the scoliosis. Observations on the patients who were followed for more than six months indicate that the pleural thickening underwent a slow but steady thinning out process over a

period of several months, and experience has shown that returning the patient to full duty is not warranted during this time.

SUMMARY

1. During an epidemic of beta hemolytic streptococcus infections, when the organism gained unusual virulence, 120 cases of primary streptococcus pneumonia were observed. The disease was characterized by the almost simultaneous onset of pneumonia and pleurisy with the rapid development of a massive, thin, purulent pleural effusion similar to that described during World War I.

2. Penicillin in large doses intramuscularly was effective in sterilizing the pleural effusion but did not prevent the disease from running an acute and prolonged course.

3. Thoracentesis was used frequently, but because of the effect of penicillin in sterilizing the effusion, closed thoractomy was resorted to only once and none of the cases required open thoractomy.

4. Convalescence was long and slow due to the persistent pleural inflammatory reaction and the very slow resolution of the thick residual pleural adhesions.

STATISTICS

| | | |
|---|---|---|
| Number of cases studied | 120 | 100 % |
| Number of cases with pleurisy | 97 | 80.9% |
| Number of cases requiring thoracentesis | 82 | 68 % |
| Number of cases complicating scarlet fever | 18 | 15 % |
| Number of cases with positive initial blood culture | 11 | 9.1% |
| Number of Deaths | 1 | 0.8% |

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The author wishes to express appreciation to Mr. Sheldo A. Miller, Administrative Assistant, U. S. Public Healt Service, for his assistance in collection and presentation this material.

# A NEW ARTHROPLASTY FOR SMALL JOINTS

COMDR. EDWARD H. CROSBY, MC—USNR, and LT. ROMAN E. GALASINSKI, MC—USNR

MANY operations have been described for the purpose of restoring motion to a joint and function to the periarticular structure of the joint. Such operations are done not only to restore motion to a joint which has become stiff because of disease or injury but also to relieve pain in a joint which has motion. Various materials have been used for interposition between the articular surfaces of the new formed joint namely a pedunculated fascial flap, transplants of free fat, free autogenous transplants of fascia lata, and more recently vitalium has been used in arthroplasties of the hip and head of the radius. It is the purpose of this report to present a case in which an arthroplasty was done on the first metatarsal phalangeal joint using tantalum between the joint surfaces.

A 26 year old negro marine (915473) was shot in the left foot on June 19, 1944. Roentgen examin tion reported a comminuted fracture of the dist end of the first left matatarsal bone. The patie made an uneventful recovery with conservati treatment and returned to full combat duty. C November 23, 1944, while on overseas duty, a tir ber fell on the left foot. The foot became swoll and painful. The swelling subsided with conserv tive treatment but pain in the first metatarsal ph angeal joint persisted and the patient was evacuat to the United States on December 9, 1944, for fu ther treatment. On March 17, 1945, an operati was done and the medial portion of the distal e of the first metatarsal bone removed together wi the proximal end of the proximal phalanx. Follo ing operation he was returned to duty but he cou not continue, and came under our care on May

1945 complaining of swelling and constant pain through the first left metatarsal phalangeal joint. Physical examination was normal except for the left foot which revealed generalized swelling and tenderness about the first metatarsal phalangeal joint with a well healed, slightly tender scar on the dorso-medial aspect of the joint. The slightest motion of the left great toe caused incapacitating pain and the patient had considerable difficulty in standing and walking. The pressure of an uncut shoe caused extreme pain. Roentgen examination of the left foot (see figure 1) showed a deformity of the head of the first metatarsal bone and also of the base of the first proximal phalanx due to a previous operation. A portion of the head of the first metatarsal bone had been removed on the medial side and also a portion of the base of the first proximal phalanx had been removed. There was some hypertrophic bone formation on the lateral and posterior aspect of the base of the first proximal phalanx, with the formation of a small spur at this point. The joint space of the first metatarsal phalangeal joint was decreased. All laboratory examinations were within normal limits except for the urine which showed a trace of sugar. Blood sugar and repeat urine analysis were normal.



FIGURE 1

Roentgen examination of the left foot before operation. Note the large sput extending upward and laterally from the proximal end of the first proximal phalanx.



FIGURE 2

Roentgen examination of the left foot after operation showing the tantalum cup in place.

On May 29, 1945 the following operative procedure was performed. The scar of the previous operation on the dorso-medial aspect of the left foot was excised and the head of the first metatarsal bone exposed so that the joint could be dislocated. The head of this bone was found to be considerably eroded and rough with only a small amount of articular cartilage remaining. The proximal end of the first proximal phalanx had been completely resected and numerous sharp spurs of bone were found on its articular surface. The head of the metatarsal bone was trimmed to receive a thimble shaped tantalum cup which was made from a flat piece of tantalum, 0.015 inches thick, by carefully hammering the metal over a mould of wood to the size and shape of the metatarsal head. The spurs were removed from the proximal end of the proxi-

mal phalanx and the end of the bone made smooth with a file forming a slight concavity to simulate an articulating concave surface. The wound was closed anatomically and the left foot and ankle incompletely immobilized with thick gauze dressing and elastic bandage. The postoperative course was uneventful and there was complete relief of pain in the left foot. Passive and active motion was started two days following operation. The skin sutures and splint were removed in ten days, and the patient was able to bear weight on the left foot 14 days after operation with only moderate discomfort. Two months after operation, examination of the left foo showed moderate shortening of the great toe with sufficient motion of the first metatarsal phalangea joint to permit walking with uncut shoe. Swelling and tenderness about the operative site had com pletely subsided with very slight tenderness on th plantar surface of the joint. Roentgen examinatio (see figure 2) showed the tantalum cup well seate with no proliferative changes about the joint. Si months following operation, tenderness about th operative site had completely subsided and patien walked without pain and a hardly noticeable limp

# LETTERS FROM MEMBERS IN THE ARMED FORCES

## From Major George L. Tunick, AUS

Philippine Islands,
12 June 45

Now that things are settling down I would like to tell you of our newest venture in the Philippine Islands. As you may know I have been in command of this Clearing Company since coming overseas. It is the most fortunate thing that I find ample time to continue my medical practice in addition to my administrative duties.

We landed on this particular island a few months ago and occupied this city within a few days. It was most surprising to find that due to a hasty retreat, the Japs had no time to destroy the city. It was our good fortune to be able to take over a completely intact 150 bed hospital. It includes a group of modern buildings and has a capacity of 150 patients. The grounds are beautiful with hedges, flower gardens, and large lawns. Only two weeks before we arrived the Japs planted banana trees in our front lawn, but as yet there are no ripe bananas.

The hospital is complete in all its furnishings and is a red roofed, two story building, built around a concrete patio which has a circular flower garden in the center. The O.R. is of white tile, is light and airy, and has been used for numerous cases. The Japs destroyed the tube in the x-ray apparatus, and punched a few holes in the transformer of the fleuroscope. The latter was repaired and is being use daily. The entire hospital is one that any town woul be proud of.

Adjoining the main hospital building is a beautif chapel, that was donated in 1937 by a family i Pittsburgh, Pennsylvania. The Japs had utilized as an additional hospital building.

The entrance into the hospital is between tw stone pillars and the gravel driveway courses to th hospital in a circular fashion. It passes under an ove hanging balcony which has a tile floor and on whic the chaplain and I make our living quarters. All i all this particular set up is the best I've encountere overseas, and regret to say that we probably wi not be as fortunate again in finding such a complet and intact hospital.

The social life in this town goes along at a goo pace. There are dances for officers and enlisted me Moving pictures are held in the town theater and is certainly nice sitting in comfortable wicker chair Several times there has been a 17 piece band at th hospital for entertainment of the patients. We r ceive numerous invitations to dinners in town. W have had some interesting medical meetings in th homes of various Filipino doctors, and some inte esting cases have been demonstrated.

It may appear that much of our time is bein spent with recreation and entertainment; this

definitely not so. We run at full capacity continuously and the number of patients treated in the last two months would greatly surpass that of a similar civilian hospital; however, it is a happy combination for all concerned and we hope we will continue occupying these buildings for some time.

Best wishes to all members of the Society, and anticipating the next issue of the JOURNAL.

George L. Tunick

## From Major Wilson F. Smith, AUS, Hartford

Stark General Hospital
Charleston, S. C.,
18 June 1945

Every month for the past year, when the CONNECTICUT STATE MEDICAL JOURNAL arrived, I have tried to get a letter off to you, but have been interrupted before it was done. After reading Dr. John Leonard's article in the March issue, I had a note to you more than half written telling you how much I was interested in his subject, "The Community Hospital and its Out Patient Clinic," but I never quite finished it. I have always felt that a good OPD gave more advantages to the practicing doctor than it did competition. It was the only lack I found at the Hartford Hospital.

The JOURNAL's cheery red and white cover is a familiar sight at this hospital, for it is on the desks of both the assistant chief of the Surgical Service (Capt. Leo Hymovitch of Stamford) and of the assistant chief of the Medical Service (myself). I particularly enjoy reading the letters from our Hartford doctors in service, in fact it is the only news I get from some of them.

My work here is very stimulating, because our peculiar set-up as a debarkation hospital provides us with a large and continuous turnover of patient. These we may examine and study for a few days before they are moved on nearer their homes. We have seen many unusual and interesting cases come through with each shipload, and have been able to hold good "teaching clinics" several times each week. I am particularly impressed by the splendid work-ups and treatment that these patients have received overseas.

Nearly every ship has some friend or acquaintance on it. Quite recently Lt. Col. George W. Hebard of New Canaan came through here and we had a pleasant reunion. The reunion I am really looking forward to, however, is the H. H. staff outing after we are all back in practice again—oh, happy day!

Wilson F. Smith

## From Lieut. Roger B. Nelson, USNR, Waterbury

U. S. Naval Air Station
Anacostia 20, D. C.
July 15, 1945

Ever since your letter about the Army-Navy issue of last year I've been intending to write but that date slipped by before I got to it and then I kept putting it off. I see each issue carries letters so maybe this will do for one or maybe will be on time for this year's Army-Navy issue.

First let me take care of a change of address from the U. S. Naval Dispensary, Navy Dept., Washington 25, D. C., to the above address.

For all my 2½ years of active duty I have remained a dry land sailor so have no exciting or even too interesting experiences to relate. I've moved about a bit but always the East coast and always in sight of the Atlantic. Jan. 4th, 1943 I started off at the Brooklyn Naval Hospital. Three weeks later moved out to Long Beach, L. I. While there I did general medicine and some E.N.T. Two months later back to the Brooklyn Naval Hospital to do Obs. & Gyn for Navy families. That only lasted 6 weeks and I was off to Florida, a station called Banana River—an interesting name but no one had ever hear of it. It turned out to be a fine air base and I had 9 rather busy months looking after Navy families stationed there. Then a short jump of 70 miles to Ft. Pierce, Fla., and training with the amphibious forces. The training was entirely physical, in fact the 9 months spent there had little medical practice. My destiny was overseas but Nov. 1944 I was ordered to Washington and back to Obs & Gyn practice. The volume was great and the experience refreshing after so many months lay-off. In June I moved across the river to this air station of Anacostia where I have the care of some 500 WAVES as my responsibility. This is proving to be a very pleasant assignment. How long it will last I have no idea. I'm over-ripe for sea duty so can expect a change any time.

Have received the JOURNAL regularly. It seems to be improving all the time. Enjoy reading the letters from others and enjoy the numerous articles and reports on present day trends toward socialized

medicine and the activities of the Society to control and direct the trend.

The Navy's dependent clinics are certainly socialized medicine on a fairly large scale. Large numbers are being exposed to it and I'm afraid some are going to expect a continuation of it after this is all over. E.M.I.C. is adding further fuel to the fire although I certainly don't begrudge the financial aid it gives those in the lowest pay grades. Lord knows they earn little enough. My experience in the mass production care has certainly made me feel more strongly than ever against it.

Keep up the good work at home and I hope it won't be too many more years before we will be back there.

Sincerely,
Roger B. Nelson

## From Major Maurice R. Moore, AUS, Norwich

Medical Service 3539th AAF BU (ROS)
Regional Hospital
Office of the Chief of Laboratory
Langley Field, Va.
17 August 1945

Now that the war is officially over we are all looking keenly to our return home, and reflexion on our years in the service seems in order.

Three times it has been my responsibility to take groups of untrained soldiers and mold them into a staff of laboratory technicians. To these young men goes great credit in that they have produced excellent technical service with a minimum of guidance and supervision.

This technical training will not be forgotten when the soldier returns to his civilian status, and he is going to require the benefits of careful laboratory analysis when sickness comes to his home. The number of these men is sufficient that they will influence our entire country so that clinical laboratory procedures will be significantly increased.

This attitude is indeed a wholesome one and should be not merely accepted by the medical profession but must be encouraged. Much might be said in support of this probable potentiality in that great numbers of amoebic infestations, low grade malaria cases, etc., can be discovered only by careful laboratory examination by those specially trained in such examinations.

I greatly appreciate receiving the CONNECTICUT STATE MEDICAL JOURNAL. Not only does it carry many interesting medical articles but also it has been from "home" and kept me aware of the activities of many of my friends.

Maurice

## From Captain Jean Henderson, AUS, Stamford

376 St. Hosp. APO 503,
c/o P.M. San Francisco, Cal.,
31st October 1945

In answer to your letter asking for news from doctors overseas, this is an account of the saga of a female of the species.

It was two years ago that I reported for duty at Des Moines, Iowa. After being there several weeks, orders came sending me to Atlanta, Georgia, where, at Lawson General Hospital, women doctors were being given a basic training course in matters military, roughly equivalent to that given at Carlisle Barracks. From there I went to my first assigned post at Ft. Knox, Kentucky, where I spent nine months, first in the attending surgeon's office taking care of families of army personnel living on the post, and later as ward surgeon in the Regional Hospital there. Just as I had settled down to really enjoy the battle of Kentucky for the duration, orders again arrived sending me to Wakeman General Hospital near Indianapolis at Camp Atterbury, where a technicians school was being started for WACS. After the first shock of finding myself in a teaching position expected to turn out medical and surgical technicians rather like Ford cars, two months passed during which time I am sure I learned a great deal more than the embryo technicians. Then in November '44 I was sent to Camp Berkeley, Texas, to await overseas orders. This was what I had been demanding eagerly for many months and I went down to Texas hopefully expecting to hop the next boat, but Thanksgiving, Christmas and New Year's day passed before a group of Station Hospitals was activated and I was assigned to one of them. This too proved a false start as while I was in parallel training with them at Camp Joseph T. Robinson, Arkansas, the unit was temporarily deactivated and I was transferred to Ft. Sill, Oklahoma, where I joined my present outfit, the 376th Station Hospital, which was training for overseas duty. We remained at Ft. Sill until April when we left for the west coast and on 7th May 1945 we set sail from Seattle for the Pacific area, destination unknown. We had a long

cruise of eight weeks on the Admiral Kepp, a two stoker AP transport, and though we went through dangerous waters we were not attacked by air or sea and our chief complaints were that we were only getting two meals a day and that the trip was too long. We had two stopovers on the way—at Eniwetok and Ulithi where we were able to get ashore, before we reached our destination, Okinawa.

When we arrived at Okinawa the island had been declared secure for about ten days. It was a moonlit night with a calm sea and no air raids, for which we were thankful, as we gathered up our musette bags and helmets, after a ten minute notice to get off, and crowded onto a landing barge. We didn't see much of the island that first night, as the rain and mud of the invasion season were over and clouds of dust swirled around us as we drove in trucks along roads already built by the CB's and engineers. Disembarking on foreign soil was much more exciting and never to be forgotten than leaving the U. S. A. had been. I found that being a female overseas meant that I didn't have to bivouac on the beach and eat tinned rations with the other docs but was taken to nurses' quarters where tents with cots and a mess hall were already set up. However, it also meant that one lived in a "compound" surrounded by barbed wire and armed guards and warning flares, that you left it only in company of an armed escort returning to the area at 7:30 P. M. and to your tent at 10 P. M. At first I resented these restrictions but came to realize they were safety precautions and that snipers and air raids still made the island dangerous.

Okinawa where war and construction had not changed its face was a green and rolling wooded country, half tropical and half temperate with rice fields, banana trees, bamboo, cane, sweet potatoes and pines and cedars and steep and rocky cliffs with sandy beaches and swimming. It was very hot but we had cool nights. When it rained the mud was awful—thick, deep and clay like. One of the distinctive features was the number of caves used by every family to house the bones of their ancestors. The tombs varied in size but the general shape of the structure and terracing around them was built to resemble the female uterus and tubes. The principle city, Naha, was my first sight of what war could do to a city—where about 60,000 people had lived, there was nothing but rubble. Here and there the concrete framework of a few buildings still stood and there were a few little little railroad cars near what had been the station. In the outlying districts the buildings were not modern; the native huts are small and low with conical thatch roofs. The natives are known as "gooks"; they are small and wiry and look oriental. The women seem to do most of the work. They carry loads on their head or suspended on either side of a wooden yoke worn across the shoulders, they work in the fields too and wash and cook what food they have, usually with the last baby hung on their back at the same time. They were quick to pick up words and expressions of ours and were soon able under supervision to wash clothes, polish shoes, and later on operate the washing machine and iron as well as do some of the heavier outdoor work. Aside from sight seeing we found we were not to set up our own hospital but to be quartered and work with the 233rd General Hospital, which was in process of setting up in the southern part of the island using a former Japanese military school as a nucleus. A building in fairly good repair was used for surgery and tents had to be put up for everything else. Beside this, furniture such as desks, cabinets, chairs, sheet racks and wash stands had to be built of any lumber that could be begged, borrowed or stolen. Nails were scarce and I remember my first and most valuable work contribution was to straighten bent used nails so they could be used again. In August we were finally ready to open. I think our first patient must have wondered what rare malady he had as so many medics gathered around to see a real live patient.

I was assigned to the contagious section which turned out to be an interesting service as we got all the fevers of unknown origin and the dengue-like fevers, another favorite admitting diagnosis. Our first patient proved to be a typhoid fever case and we saw a good many of the typhoid, para typhoid group. We also saw malaria and infectious hepatitis and besides these intestinal parasites, dysentery and two amebic liver abscess cases. There was some encephalitis also. I only saw one soldier with filariasis although it was said that 30 per cent of the natives over 40 years had it. As far as I know no schistosomiasis originated on Okinawa although the ground was littered with snail shells. In our time jeep accidents provided most of the surgery as the Okinawa mud made the roads perilous.

We kept fairly busy and survived various events, there was a V-J day celebration with live ammunition, a small earthquake and the tail end of typhoon No. 1 which necessitated moving patients, including a bleeding typhoid, from tents which were collapsing to half finished quonset huts. The last group of

patients I had were the most interesting, being some of our boys as well as British and Dutch who had been prisoners of the Nips since '41. Far from being reticent or withdrawn they were so happy to be among their own people and so eager for someone to talk to that they could not stop talking and we heard many tales of horror and cruelty. Among them we saw all stages of malnutrition and tuberculosis and the amount of food they could eat was never to be forgotten.

Now that the war is over Okinawa has become more civilized; we were living in tents with floors and side walls and decorative parachutes lining the ceilings; we had electricity—radios, irons, washing machines. Officers clubs were opening. There was talk of hot water showers. We still leaned out the front door and cleaned our teeth but we had a front door. So just as we were getting quite comfortable and thinking of how many joints we still had to leave before we got home we got orders for our unit to proceed to Japan.

We left in L.S.T. boats just in time to avoid the typhoon No. 2 which was lucky for us as from all accounts that really hit Okinawa. Our voyage was prolonged by the fact that we had to travel 36 hours out of our course to avoid the storm and dodging typhoons on an L.S.T. is quite a rough affair, however the Navy fed us the first fresh food we'd had in some time and my Connecticut salt water training stood me in such good stead that I did not lose or miss a meal.

We landed at Yokohama, all arising at dawn to see Mt. Fuji which of course was obscured by clouds and instead we saw the ruins of the once busy city. The B-29's in one short raid sure wrecked the place, but when we once got ashore we found blocks in the business district where things were comparatively untouched and other places where families are putting up shacks of rusted corrugated tin and any lumber they can salvage amid the rubble. The natives are standing in line for food rations—packages of corn, rice and fish mixtures, and fishing out of the dirty waters and netting bits of food from the garbage thrown overboard along with the sewerage from boats in the harbor. They also are spreading their wares on the sidewalks and selling assorted junk at exorbitant prices to the GI's and sailors that throng the streets. Cigarettes or candy are worth more than yens and sens. We have seen a little of Tokyo which is also pretty well desolated in spots.

Now we are operating our own Station Hospital for the first time since the start of our travels, in an area about 20 miles n.w. of Tokyo near the Tochinawa air strip. We are occupying a former Japanese hospital which must have been quite a large one once. It was situated near a large airplane factory and that was pretty well bombed. It is a fairly isolated rural district but we have a nearby train by which we can get into Tokyo, and all around it is like the old elevated in New York. We took over from the 7th Evac. Hospital. Our main problem at the moment is patching up the flimsy buildings, replacing shattered window panes, etc., and getting heat. After the tropical suns of Okinawa, Japan is cold and rainy. We have just obtained stoves run on diesel oil and are now fairly comfortable but until now it was almost cruelty to dig the patients out from under the blankets to examine them and we already have several nurses down with bronchitis and pneumonia. So far our census is low which is fortunate and gives us time to get organized. We are seeing beside upper resp. infection, malaria, jaundice, diarrheas and a good deal of skin disease—scabies, and fungus infections which do not clear up well. This is all very new and recent so we haven't really had time to know what we are up against. Mount Fuji on a clear day is snow capped and beautiful and looks just like the pictures. The little native girls that serve us meals in their kimonas and wooden clogs are pretty, bright and willing. I haven't attempted to learn the language except for "good morning" which sounds like Ohio and is easy, but they understand gestures and signs very quickly.

This is a verbose, too long and rambling account but as you can see it has been a wandering career I've had in the last two years. Perhaps some part of it may be of interest.

My best wishes to you all in Connecticut and I assure you I'd rather be there than here.

Jean Henderson

## From Captain R. Keeney, AUS, Manchester

August 25, 1945

It has certainly been a ray of sunshine to receive the JOURNAL which is so full of news and appropriate articles.

I believe the issues are improving monthly and many of them require careful reading and thought.

After completing a course of training at Carlisle, I came here in November '43 and was assigned to the medical out-patient clinic to provide medical care to military dependents at no cost and also to civilian workers and their dependents living within

a ten miles radius of this field at a cost of $0.50 per office visit and $1.00 per house visit.

After a trial of this kind of government controlled civilian practice, I was transferred to the "Section of Industrial and Occupational Medicine" in April '45.

This work involves caring for the civil service employees employed on the field in maintenance, repair, etc., of aircraft. This new industrial medicine has opened a new field of medicine to me and has been very interesting.

I am looking forward to an early return to private practice in Manchester, Conn., as soon as the Army will release me.

I will greatly appreciate receiving an issue of the State JOURNAL at the address given.

Bob Keeney

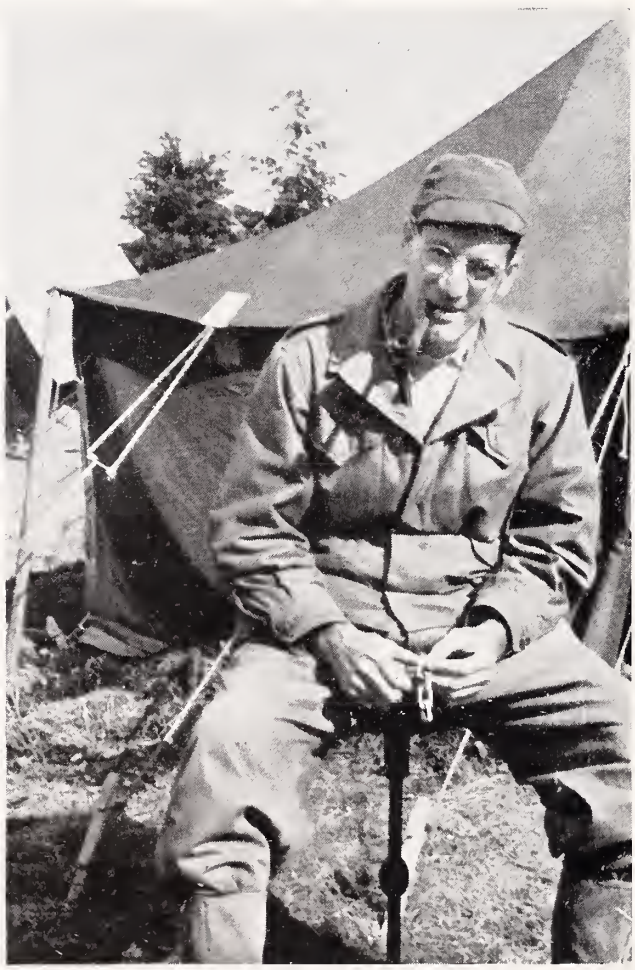
## From Major Wilson F. Smith, AUS, Hartford

107th General Hospital
Fort Lewis, Wash.,
1 October '45

I wish I were in a position where I might work up a case report or short article for your December issue of the CONNECTICUT STATE MEDICAL JOURNAL, but right at the moment I am further removed from things medical than I have been during the entire three-plus years of my army service. I left Stark General Hospital—where, incidentally, there was more to be seen medically in one week than you'd expect to see in a month at a regular general hospital—toward the end of August and reported out here to a hospital unit that was supposed to sail for the Pacific on or about the first of October.

My life out here has been amusing, if you can maintain your sense of humor. Remember that all of this takes place after the Jap surrender. First of all, we had to draw field equipment, then we went to work learning how to use all sorts of combat weapons, how to set booby traps and demolition charges, and lots of other useless information. We then went out on a two week bivouac, that was fun as a camping trip, but a shameful waste of time and money. Many doctors went through all of this during the war, and probably found some of it useful in their experiences later on in the Pacific, but the momentum of army procedure forced us to go through it all, even after it was found out that we would not be going overseas.

There were half a dozen other hospitals in the same boat, but they received their inactivation orders just as we were leaving for bivouac. All our medical officers, but one, were ordered back to their original stations while out in the field, though they were made to finish the bivouac before they could leave. I was the one lone exception. My orders have not come through as yet, so here I sit in a dying outfit with no colleagues to keep me company.



Major Smith, the whittler

Fortunately this is a beautiful post and I am finding all sorts of hobbies to keep me occupied. I am playing lots of tennis, doing my own photographic finishing, and fooling around with some woodworking. The unfortunate thing is that my family are over 3,000 miles away and the gang in my old office building are talking about having my office ready for me again.

I hope that by the time your December issue comes out I'll be nearer home and nearer discharge from the army.

Wilson

P.S. The enclosed photo shows how I spent two weeks on bivouac, whittling a chain out of wood.

## From Lt. Comdr. R. A. Goodell, USNR, Hartford

Okinawa,
Oct. 3, 1945

Your letter of September 10 finally found me here at Special Augmented Hospital Number Four which is the name of our hospital unit and not the name of a new secret weapon.



A beauty from Okinawa

After several pleasant months in so called "sunny" California, last May we finally sailed under the Golden Gate Bridge, an experience I would like to repeat. We were fortunate enough to get a large and fast ship of the President class which in peacetime used to take freight and passengers on around the world cruises. Just think we got the trip for nothing except the usual mess bill which the Navy clamps on an officer wherever he is.

We had an excellent skipper who had been in most of the major invasions in the European theatre and out here. He had brought the ship through without a scratch and he had been decorated twice for bravery. One night one of the passengers opened a valve out of idle curiosity and partly flooded a magazine. The Captain's talk over the ship's loud speaker system was a classic. It had all the words of a Sunday school talk only used in different order.

Medical officers had various battle stations with first aid equipment during general quarters. My command assigned me to the bridge either because they thought it the most dangerous place or because they thought I might get on well with the skipper. Anyway it was very interesting up there and I swapped many down Maine yarns for deep sea stories.

We approached Okinawa without mishap and came ashore at night and we were glad to get on land as the Jap suicide planes were still active.

Coming down the side of the ship on a cargo net one of our doctors lost his helmet and konked another doctor far below, but no serious harm done.

After getting ashore we had to wait for our hospital to be built and as we had no duties it made a good time to explore the island. We are located quite near Naha and Shuri but there is not much left to see but ruins.

An ambulance brought a patient from the northern part of the island and I rode back in the ambulance to see Dr. Frank Guiffreida of Middletown who is with the First Marine Division. Frank had been here since "D" day and had really seen some rugged fighting with the Marines. It took 4½ hours to go 50 miles but the country is beautiful with steep green mountains coming right down to the sea. The road follows along the coast and the interior is wild. I was fortunate enough to get a ride back by plane which gave me a wonderful view of the island.



Ruins at Naha, Okinawa

From the air the island is even more beautiful with different shades of green representing rice paddies, fields of sweet potatoes, and sugar cane. Also I was able to see the shell holes, ruined villages, wrecked planes and tanks which made me realize what a pasting our boys gave this place. I was particularly impressed by a cruiser or destroyer sitting upright on the bottom of the bay but perfectly visible through the clear water from the air. I don't know if it was a Jap ship or ours.

Now our hospital is open and it seems strange that we have as many beds as the Hartford Hospital had when I served my internship. We have many interesting cases including men who have been in

the Philippines, China and Japan as well as those who have been stationed here on Okinawa.



Doctors of SAH No. 4

We at present have some men from the Dutch army who were prisoners of the Japs for over two years. Two of them speak English. They were all suffering from nutritional deficiency and they think our B and C rations are wonderful. We think they are putrid. The Japs had the Dutch patients working in a coal mine and Okinawa seems like a fine place to them. Personally I think it would serve the Japs right if we gave the place back to them.

Bob Goodell

## From Commander Reinhold F. Hertzberg, USNR, Stamford

10 October 1945

It was nice to hear of the society's activities but nicer still to hear today that the Navy has lowered its point score for the discharge of medical officers. With my 54½ points I hope it won't be too long before I am back in Stamford—if I can ever get off this Pacific rock.

However, I feel that I have been luckier than most of our doctors as in more than three years of military service there have been but a few months when I have not been doing major surgery. I was on Oahu when the Saipan casualties arrived; those we cared for were mostly mortar injuries and many were quite horribly mangled. The factors which contributed most to the low mortality were the free use of whole blood, penicillin and leaving foreign bodies in situ if they were not causing trouble.

I left Honolulu in July of last year and landed on Tinian in the Marianas, after 58 days on shipboard, where we established a Naval Base Hospital. Most of our island casualties were from sniper fire and we had some very interesting chest and abdominal injuries. Our next big job was caring for the B-29 aviators when they first started bombing Japan before the Army hospital was established. Very severe casualties came in from Iwo Jima, mostly from mortar, rifle and machine gun fire. Many of these were rectal injuries with fistulas appearing in the most unexpected sites. Of course our worst injuries were from the Okinawa campaign, when the Navy was really pounded. These were mostly deep and extensive burn cases, the result of Kamikaze attacks. The local treatment which we like the best was vaseline gauze pressure dressings left in place for ten days, then removed, and the patients given a daily bath followed by spraying with a paraffin-sulfa mixture. We soon discarded the use of stockinette as a cover for dressings as in this climate it seems to act as an ideal incubator for fly maggots. The thing which has impressed most of us is the seemingly inexhaustible vitality of these young boys which enables them to survive injuries of awesome magnitude.

I was pleased to receive my promotion to Commander as of last July 10.

Recently, I received an appointment as Chief of the Surgical Service of this base hospital but all I want now is to come home.

Reinhold F. Hertzberg

## From Lt. Col. W. C. Townsend, AUS, Hartford

10 October, 1945

For the last issue of the Army and Navy number, it may be of interest to summarize briefly the work of a typical station hospital in the Mediterranean theatre. The hospital was organized on the basis of 500 beds, but its daily census averaged about 700 patients. Except for brief periods during change of station the hospital was in continuous operation from 12 July 1943 to 18 June 1945.

In its first location at Bizerte, North Africa, the hospital worked for about a year and functioned in various capacities. Its chief duty was to care for troops stationed or staged in that area, and it also received casualties directly from the Sicilian and Italian fronts, and in addition acted as a general hospital, receiving transfers from forward hospitals. The next station was at Naples, where the hospital acted as an evacuation center for French casualties

at the time of the invasion of southern France. The last location was at Leghorn, where the hospital functioned primarily as a station hospital servicing troops in that area.

Altogether 17,703 soldiers were treated, and of these 9,285 were medical patients. Malaria was the chief medical disease—1,495 having this as their primary diagnosis. In Italy the picture was different from that seen in Africa. Only one-third of the total cases were seen, and the majority were recurrent and of the benign tertian type. The clinical and laboratory diagnosis was easy and the treatment routine. In Africa, because the disease was epidemic and included the falciparum type and because preventive measures and individual prophylaxis were poor, the incidence was high and the disease was severe, hyperpyrexia, prostration and cerebral, pulmonary and renal complications were common. Dysentery was often concomitant, or a manifestation of the malaria, and added to the gravity of the case. Immediate treatment with intravenous fluids and quinine was imperative. At a later date atabrine was substituted for the quinine, and we found that an initial intramuscular injection of 0.4 gm. of atabrine dihydrochloride was so satisfactory that we instituted it as a routine measure in the treatment of all cases.

The enteric diseases were next in importance and the great majority were due to bacillary dysentery. A total of 927 patients were treated and, as with malarial fever, over two-thirds were seen in Africa. Here again the tropical and unsanitary living conditions were responsible for the high incidence and severity of the disease. Chemotherapy with sulfaguanidine was routinely exhibited, and was highly successful. Because of the vaccination program only 18 cases of typhoid fever were seen, and most of these cases were in French soldiers. As our service overseas lengthened more cases of amebiasis were encountered, 34 being so diagnosed. Most of these were carriers. A few had amebic hepatitis and responded dramatically to emetine.

Seven hundred and sixty-four patients were hospitalized with infectious hepatitis. This disease was extensively studied in this theater and considerable progress was made in its classification, etiology and treatment. The cephalin flocculation and bromsulfalein tests were the best diagnostic aids, and plasma in the early stage and absolute bed rest and a very high protein diet were the best therapeutic aids. In our experience the diagnosis of hepatitis without jaundice was too frequently made. Water or food contamination has been considered the chief source of the infective agent. However, in Italy we found that the morbidity and the severity of the disease remained high, while the rate of the diarrheal diseases declined markedly, suggesting that the responsible virus has another portal of entry.

In Africa the respiratory diseases were at a minimum, but in Italy the rate was about the same as in this climate. One hundred and forty-three cases of primary atypical pneumonia and 86 of bacterial pneumonia were seen. During the last winter atypical pneumonia was seen in an epidemic form. The chief complaint was a severe frontal headache, physical signs were few, prostration was marked and the febrile state usually lasted 14 days. Both sulfonamides and penicillin were tried without benefit. The pneumococcal pneumonias responded so well to sulfadiazine that it was rarely necessary to give penicillin.

One thousand one hundred and fifty-six cases of venereal disease were treated, of whom 293 had syphilis. For two months our hospital was a venereal disease treatment center, and during this time one half of the above number of patients were treated. Notwithstanding, the figures denote the high incidence and would indicate that better preventive and social standards are in order. On the whole our experiences with penicillin were satisfactory. Two disturbing elements were the number of cases of secondary and tertiary syphilis in whom the primary stage was missed, perhaps by the administration of penicillin for treatment of gonorrhea, and the number of relapses following the standard treatment of syphilis with penicillin.

Primary psychoneuroses were diagnosed in 710 patients, the majority having an anxiety state. Of these about one half were not considered suitable for combat duty. These figures would be much higher but for the fact that obvious psychoneurotic disorders were admitted to specialized centers.

There were 9 deaths during this period of service. Three died from acute necrotizing hepatitis; two died from acute tuberculosis pneumonia; and one each died from a flash burn of the lungs, diphtheria with complete heart block, malaria with hemoglobinuria, and acute bacillary dysentery.

At this time it would be fitting to express to you the appreciation of all the Connecticut men in the service, not only for the receipt of the JOURNAL, but also for the high caliber of its format.

Bill Townsend

## From Lt. Comdr. Samuel B. Rentsch, USNR, Derby

In July of this year (1945) I had the opportunity of visiting a native hospital on one of the islands in the . . . Pacific. I thought recounting this trip might be of some interest to your readers.

The trip was made by jeep through much rain (which is a daily occurrence out here). The man who arranged the trip was Major B— who has been here stationed at the Army hospital for 18-plus months. On the way to the hospital we traveled through jungle and visited a rubber plantation, which in itself was a very interesting and worthwhile experience.

We were met on the grounds by Lt. A—, an Australian doctor in charge of the medical service for the natives. The hospital grounds were well arranged and well kept, there were many flowers, all native to the jungle, and which had evidently been transplanted under the direction of someone who had considerable training in landscaping. The walks were about three feet wide except the main thoroughfare which was about ten feet wide. The walks were of river gravel, brownish in color and seemed the same lava flow which we found on the beaches.

Across the drainage ditches which laced the grounds and surrounded each building, were bamboo slats four to six inches wide and four to five feet long. The ground was not swampy, but because this was the rainy season the ditches were running with water. They were certainly needed for otherwise we would have been paddling through water over our shoe tops.

The Sergeants, in our parlance, orderlies, were bareheaded, wore scivie shirts and shorts, and were barefooted. The native men wore the usual loin cloth only; the women sported the greyish-red "grass" skirt which covered them from their lower abdomens almost to their knees.

Dr. A— was anxious to have Major B— see several cases with him so we went without delay to one of the female buildings. This building which was typical of most of them, was about 40 feet wide by 60 feet long and was floored with gravel the same as the walks. This, by the way, is the same in the homes of the natives, so evidently it was a touch of home for the patients, for it seemed as though the whole family went along with the member to be hospitalized.

The walls of the building were only partly closed in, and were made of the native palm leaves and grass woven into matting. The roof, which was supported twelve or more feet to the square by tree trunks, was thatched and, while light could be seen in places, it was quite secure as to water tightness.

All around the walls about three or four feet from the ground was a shelf or shelves, made of split bamboo about six feet long and four feet wide. In some buildings these shelves were continuous around the walls, while in others they were divided. The patients lay or sat on these, with usually a thin, not too clean, bedspread or an Army blanket over them.

Everything seemed to be free and easy. Most of the patients were good natured looking and smiling, although some wore disagreeable frowning expressions which was common among the natives seen at work on the roads. Dr. A— told me when I inquired if they were appreciative that in his ten years work with them, he had been thanked but once!

The first woman Dr. A— showed us had a yaws (tropical syphilis) leg ulcer. We saw these on all, adults and children too. They occurred mostly on the lower third of the leg, but one which had just been admitted was on the calf of the leg. These responded well to arsenicals and then the skin defects are pinch grafted; this is done by the native Sergeants. Many of the scars are white, and the pinch grafts are black, and the place they are taken from is white, so it makes a rather bizarre picture, a white scar with black spots in it, and a black donor area with white patches.

One young girl about 16 had a yaws infection of her face which almost closed her right eye and almost prevented her mouth from opening.

Postpartum breast abscesses are not uncommon. The breasts of these women, having never known a brassiere, are all pendulous, some almost to the umbilicus, but there were no retracted nipples. Even the nursing mothers had flat flabby breasts and all the babies I saw looked half starved. The doctor told us that of a hundred children born, there would usually be but nine or ten left at the end of ten years.

One amusing note was that some of these women seemed self-conscious and tried to shield the upper part of their bodies by their arms, evidently a result of some civilization in their association. The skirts they wear, and skirts is really plural for some wear as many as twenty which makes a bustle effect all

around, are quite adequate covering as can be imagined.

Osteomyelitis is common, and of course quite advanced in most cases. One boy about six had fallen from a cocoanut tree and had a compound depressed skull fracture. He seemed to be doing quite well. Another 16 year old boy had an old compound fracture gun shot wound through the lower third of his right femur. This had healed so that his foot was pointed outward and the wound-site was quite tender and painful. Dr. A—— told us that he insisted on sleeping with his hands above his head in a basin of water, for he thought this helped the leg pain. His hands were almost raw from the moisture. One boy had an untreated elbow injury of a year's standing and it had healed so that he could not bend the elbow. One man who looked to be over 70 occupied a corner shelf and the doctor said he was a prisoner, having gotten into trouble over women. He had bilateral elephantiasis which was not very advanced, his legs were only moderately enlarged.

Three men occupied a hut to themselves and had leprosy in the early stages; their eyebrows were gone and the skin of their faces was somewhat thickened.

I think the most astonishing things to me were the small children between the ages of three and five, the great majority of whom had pot bellies and spleens that came below their navels. Dr. A—— said they had malaria, and probably hookworm, since 90 per cent of the natives had hookworm. None of these kids appeared to be sick, one in particular was a great favorite of the doctor's. She was quite pleased to have us poke her tummy and munched on a boiled sweet potato as large as a man's fist during the examinations.

Things were quite clean and the smells were not bad as hospitals go. There were six or eight or these buildings, the present census was about 160 but the doctor said that at times he had as many as 400 patients. They feed themselves mostly; the beneficent government furnishes bully beef and rice and they add to this diet the vegetables and fruits which they grow and are found wild on the island.

The native help live in buildings much like the hospital buildings, the floors are made of split bamboo supported 3-4 feet from the ground. The shelves of split bamboo appears to be the main article of furniture.

The hospital has neither microscope or x-ray so that one feels the good doctor is doing a wonderful job with the little he has to do with.

We talked at some length to a Sergeant who was detailed there on malarial research work. Just at present he was most interested in finding a new strain of mosquito infected with a certain type of malaria, since the strain they had been using was running out. He told us that just the previous week he had gotten 60 per cent positive malarial smears on a group of natives he had tested. He also told us that treating these people must be done by putting each dose of medication into their mouths. If medicine was issued to them for themselves to administer, they used the atabrine to dye their grass skirts or traded it for tobacco or anything else they could get.

I keep wondering if the work the doctor is doing there is worth while. Generations of these people have come and gone without doctoring. Now this war has made it necessary to take note of their misery. They certainly are a source of a labor supply to prosecute the war but they are also the source of malaria, hookworm, etc., which infects and disables the troops. The latter, I presume, accounts for the attention being given them now.

## From Lt. Col. H. R. O'Brien, PHS, UNRRA, Hartford

Manila, P. I.,
11 October 1945

Ruined cities are commonplaces in this war, but Manila is the worst large city I have seen, much worse than Naples. It is saddening to see a great hospital like the Philippine General, and a fine medical school, racked by explosives, fire and demolition charges.

I am here getting an epidemiological information service going in this part of the Far East, and discussing with the Commonwealth ways in which UNRRA can be of assistance. Recently I have been busy arranging for 900 Chinese refugees to get back to Amoy and Shanghai—immunized at that. I make the trip with them next week.

At Iloilo last month I stayed with Major B. J. Buck of Hartford, commanding the 37th Field Hospital. Here Lt. Col. Paul V. Harper of Fairfield is one of my roommates. He is assistant chief of preventive medicine, at Theater H.Q. Col. Joe Saltus of New Haven was in Manila recently.

H. R. O'B.

## From Captain H. Bruno Arnold, USNR, New Haven

105 Primrose St.,
Chevy Chase 15, Md.,
14 October, 1945

This is my first letter to you, so I will briefly sketch my career in the service.

I was on active duty for several months during the early part of 1940, being at Pensacola for two months, and then at New Haven doing recruiting duty for about three. On October 30, 1940 I began a tour of active duty, which has not yet ended, though the end seems to be in sight, and I hope to be back in New Haven, taking up private practice in the early part of January.

During the end of 1940 and early 1941 I was doing recruiting and working with selection boards for V-7 candidates—the 90 day wonders. In July of 1941 I was ordered to the Hospital Ship U.S.S. Solace during her conversion from the coastal liner S.S. Iriquois, and as part of her complement upon commissioning. I was not to stay with her long, and on September 8, 1941 I reported to the U. S. Naval Hospital, Brooklyn, N. Y. Here I was put in charge of the physical therapy department, and worked with the orthopedic department on the wards, and began courses of instruction for hospital corpsmen in physical therapy. These courses were largely practical work, with some class room work for background material. From this time on there were always from five to ten corpsmen and later also WAVES under instruction. Similar courses were being given in some other Naval Hospitals in order to provide assistants for these departments.

At one time, during this time, I received orders for the Canal Zone, but they were cancelled, and I remained at Brooklyn. Late in 1943, the Arma Corporation of Brooklyn brought a very interesting plan to the attention of the Navy in the field of occupational therapy. This involved the bringing into the hospital of certain industrial operations which could be applied to certain cases for their therapeutic value. This innovation of bringing, so to speak, a part of a factory directly into the hospital was widely utilized, and was also put into operation at the U. S. Naval Hospital, St. Albans, N. Y. There were many peculiarities about this setup, and the Navy felt that it would be best to limit the use of such projects. It may be difficult for one outside of the service to understand this, but the ultimate decision was only arrived at after much profound discussion and thought.

During the latter part of 1943 and the early part of 1944 there was evident a great deal of interest in "Rehabilitation," both in the service and out of it. A program for rehabilitation was begun, and I was placed in charge of this new development in the hospital. It meant the coordination of a great many services which were already available, and the creation of new procedures to carry on the varied concepts of a complete program. There was instituted an educational service, and then physical training was brought into the hospitals to provide another means of getting men back into shape for duty as soon as possible, and in the best possible condition.



Captain H. Bruno Arnold

At about this time, September 1944, I was ordered to duty in the Bureau of Medicine and Surgery at Washington, to take the assignment of Head of Physical Medicine Section in the Rehabilitation Branch of the Professional Division. This included cognizance of all procedures and personnel related to this field of medicine. There were many problems relating to personnel which required attention, and I made some trips to look into matters in certain localities.

During the summer of 1945, in June and July, I made a tour of all the hospitals in the 6th, 7th, and 8th Naval districts, looking into the entire rehabili-

tation program in each, with particular emphasis on the physical medicine departments. A Hospital Corps officer who was concerned with the Civil Readjustment Program accompanied me, and together we looked quite thoroughly into all phases of the program. There were, naturally, problems in some places which we attempted to resolve, and in other places we found innovations which we evaluated and brought to the attention of other hospitals which we thought might benefit by the suggestions. Most of the Naval Hospitals and Naval Special Hospitals were doing a many sided job of rehabilitation. There were some excellent pieces of work being done with difficult types of cases: for example, the cord injury or cauda equina injury type of cases. These cases, which so often are regarded as hopeless, were being taught to become independent of all help, and were being taught how to get about and take care of themselves. All kinds of ideas were brought to bear, and the progress made by these cases was compensation enough for the time and untiring effort which was expended in their care. Of course orthopedic cases and neurosurgical cases are notoriously longwinded, and for them rehabilitation in all its phases is an inseparable part of their treatment. The extent of the progress here was often hardly short of miraculous. Much of the work of the physical training phase of the program was an innovation in most hospitals and in the armentarium of the medical officers, but it found its place and contributed a large factor in the program as a whole.

It is my opinion that the basic principles of Rehabilitation have been expressed and accepted, and that they will be applied in civilian practice in much the same form they were in service, modified in accordance with the needs of the particular situation, and the interpretation of the medical profession.

In July of this year I was promoted to the rank of Captain in the Medical Corps, USNR. The present work is post war planning, and may have far reaching effects. Much of the final pattern depends on the sort of legislation the Congress will pass, and what the size and composition of the Navy will be. During the next few months it may be possible to reach some decisions on many of the problems now present. I hope to be able to contribute to this phase and see it well on its way, and then I hope to get back to Connecticut, and get down to work on some of the civilian problems of rehabilitation.

H. Bruno Arnold

## From Lt. Comdr. Samuel A. Jaffe, USNR, New Haven

USCG Training Station Hospital
Alameda, California,
October 15, 1945

Was happy to read that you are planning a third Army-Navy number of the JOURNAL. Although the war has come to a glorious conclusion, many of our colleagues are still dispersed over the various and far reaches of the earth and the Army-Navy number still sounds good to us for it serves to bring us up to date and together again.

My war experiences are as follows: After being at the U. S. Marine Hospital, Staten Island, New York, for about a year, I became a sea-going doctor. I spent seven months on the Atlantic and Pacific, feeding many fish, with my stomach doing somersaults on every wave. We did considerable convoy and escort work, antisubmarine patrol and operated with the 7th fleet. I was then transferred to the USCG Tra. Sta. Hosp., Alameda, Calif. Have since been promoted to Lt. Commander and am in charge of surgery at this hospital.

Now that the war is ended, all of us are thinking seriously of our return home and are "sweating out" impatiently the final months of our service. Our work is falling off rapidly and we have more time for relaxation. Which reminds me, during one of those moments of relaxation a couple of weeks ago, I surprised myself and everybody about with a hole in one on the 9th hole at the Alameda Golf Course.

As you can see, I have nothing spectacular to report. Thank you for contacting me. Hope to see you soon.

Samuel A. Jaffe

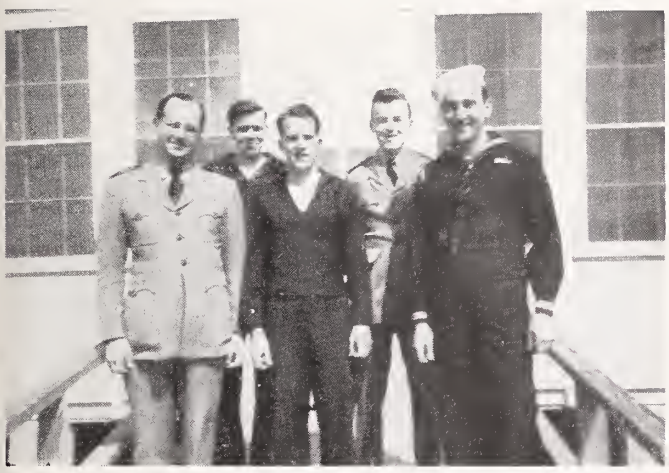
## From Lt. Comdr. John S. Staneslow, USNR Waterbury

U. S. Naval Hospital,
Shoemaker, California
Oct. 17, 1945

As per your request of the 10th of September I can give you the following information for the third Army-Navy number of the JOURNAL.

I have been stationed here since September 6 1944 and have been on the neuropsychiatric staff all this time. I have enjoyed my work and have been very busy up to the last month. After 8 months on the closed psychotic and psychotic prison ward

I was tired out and glad to get the open wards again. The duty here has been very interesting and the staff has been very congenial. The most interesting case I had was one of a split personality a la Dr. Jekyll and Mr. Hyde. He came in as a typical catatonic schizophrenic but after several pentothal sodium interviews he came out of his stupor, but had complete amnesia for a period of one year, during which time he lived with a woman in Sacramento and did some gambling in the South and had



Lt. Comdr. J. S. Staneslow, MC–USNR, an intern and 3 patients. Winter of 1944

won seven or eight thousand dollars which he spent on drink and high living. After release from the hospital he looked up the girl he had lived with from an address he had in his note book, but although she remembered him, he could not remember her. All this period is still a blank in his mind. The amazing part is that his schizophrenic features all cleared up and he left apparently in good contact with his surroundings except for the period of amnesia.

Hoping to be a civilian again in the not too distant future, I remain,

John S. Staneslow

## From Captain Harold Ribner, AUS, Bridgeport

AAF Regional Hospital
Lincoln Army Air Field, Lincoln 1, Nebraska
Office of Chief of Neuropsychiatric Section
23 October 1945

Your JOURNAL has always served as a great sense of satisfaction to us who are in the armed forces. It eases the nostalgic feelings which we all have.

During my three years in the service, I have served as a neuropsychiatrist. My first year was a most pleasant one as chief of the neuropsychiatric section at Lowry Field, Denver, Colorado. While there, I had an occasion to take part in the war time graduate medical meetings which took place in Denver, Albuquerque, New Mexico, and Tucson, Arizona, where I discussed the psychoneurotic and the psychopath in the armed forces. Since February of 1944, I have served as chief of the neuropsychiatric section of the AAF Regional Hospital, Lincoln Army Air Field, Lincoln, Nebraska, most of that time. This position also entailed serving as a neuropsychiatric consultant for 13 other satellite fields in Nebraska, Iowa and northern Missouri. Our principle task here is screening air crew personnel for B-17's and B-24's for overseas duty. This has been quite a hectic process in view of the fact that probably half a million men were processed.

We have also spent considerable time studying the psychopath in the armed forces. During this study, it came to our attention that many of the alcoholics resorted to the ingestion of the contents of benzedrine inhalers for a "lift." As far as I know, though I have not reviewed the literature, this has never been reported. Several prisoners were admitted to the hospital with acute benzedrine intoxication.

Harold Ribner

## From Lt. Comdr. Roger B. Nelson, USNR, Waterbury

U. S. Naval Air Station
Anacostia 20, D. C.,
October 24, 1945

It affords me a great deal of pleasure to inform you that I was promoted to Lieut. Comdr. on Oct. 3. I am stationed at the above address where I have been since June. I have charge of the WAVE'S Sick Bay at this activity.

Now that the war is over, is the Society doing anything in the way of putting pressure on to get our release from the service? The Navy is keeping the medic's point score so high that release even for me who has been in for 3 years is probably 6 months off. With our job pretty well over we are all most anxious to get back to our practices and get going again.

Roger B. Nelson

## From Major Ralph E. Costanzo, AUS, Stamford

Harbor Defenses of Long Island Sound
Station Hospital,
Fort H. G. Wright, New York
19 October 1945

In reply to your letter requesting information for your third Army-Navy number to appear in December, I would like to say that I have been with the Medical Corps of the Army since April 1941. At first I was surgeon with the Station Hospital at Fort Terry, N. Y., one of our island outposts, but since January 1943 I have been surgeon of the Harbor Defenses of Long Island Sound with headquarters at Fort Wright, Fishers Island, New York. We have had a wide variety of interesting medical and surgical cases. I have in mind a relatively recent case of lung abscess which responded rather dramatically to penicillin. At the present time we are busy immunizing all the personnel of the Harbor Defenses against a possible influenza epidemic. We are using influenza virus vaccine A and B as part of a general army program.

I am enclosing a recent picture of myself and staff; unfortunately our nurses do no appear.

Three of these men are from Connecticut: myself from Stamford, Capt. DiBlanda from Westport, and Capt. Rapoport from Hartford.

Ralph E. Costanzo

## From Captain Robert C. Keys, AUS, Bridgeport

U. S. A. General Hospital,
Camp Edwards, Mass.,
22 October 1945

Your recent kind invitation to write a letter for the JOURNAL has not had prompt attention because I have felt that here, close at home, I would have little of interest to contribute. I am assistant chief of orthopedics. The service has been heavy and both interesting and instructive. Much still remains to be done in surgical repair of the boys here—but not nearly as much as we have done.

Two things regarding civilian medicine are much on my mind. The first is that the threat of complete socialization is real and great for the near future. I do not believe such a scheme would benefit either the profession or the public. I trust the Society will continue to devote increasing strength in resistance to such threats.

Also I feel that cadaver material should be available to the profession at large by easy access; and I suggest that it is in order for the State Laws, which I believe now prevent, to be changed so that medical societies and/or hospitals can constantly provide cadavers.

Robert C. Keys



Reading from left to right in the top row are: Capt. H. A. DiBlanda, MC, chief medical service, Capt. Rapoport, DC, dental surgeon, Capt. Rex Iler, MC, recently separated from service, 1st Lt. Resnick, SC, sanitation officer, Capt. W. S. Nerone, MC, surgeon; bottom row, left to right: Capt. B. Bell, MC, EENT service, Major R. E. Costanzo, MC, commanding officer and surgeon, Major Friedenthal, MC, surgeon, recently separated from service, Capt. M. A. DeConti, MAC, recently separated from service.

## From Lt. Comdr. R. Starr Lampson, USNR, Hartford

U.S.S. Missouri,
New York Harbor
October 23, 1945

In reply to your letter, here is a brief account of my experiences in the war.

On June 11, 1944 I reported to the new battleship Missouri for duty as one of four medical officers, and on that day with pomp and ceremony the stars and stripes were first hoisted to the main mast and the Missouri became a ship of the U. S. Navy. Most of the crew were as new as the ship herself, some had grown up with other ships before and been off to the war. Together we assembled, novice and expert, to make the ship our home and to do our part in bringing this struggle to an end. The growing pains of the shakedown were finally over and in January of this year we arrived at Ulithi to report for duty with the Fifth Fleet and were assigned to a fast carrier group in Task Force 58.

Our first mission was to participate in the initial carrier air strikes against Tokyo, and on February 16 and 17 we were less than 100 miles from Honshu, where our planes were highly successful in their attacks. I might say that being so close to Japan gave rise to certain emotional responses which were not quite what one would have on a quiet Sunday afternoon at home. The strike was, however, accomplished without even a challenge from a single enemy plane. The surprise, thanks to the bad weather, had been complete. We withdrew to operate near Iwo Jima and provide air support for that bloody campaign. Here, we first fired our guns in anger and an enemy plane burst into flames and splashed, our first. We took part in the strikes and bombardments against Okinawa, and in the final attacks against Japan which gave us two opportunities to shell the "Land of the Rising Sun" with our big guns.

During the Okinawa campaign, right after the Yamato was sunk, the Missouri was hit by a Kamikaze, which started two small fires, but not a single person on the ship was injured. On the next day we sustained a very near miss with a Kamikaze and a bomb, which exploded under our stern and this huge ship shook like a pine plank over a brook, but again no harm was done. We have not lost a single man in battle, several were wounded, but all have recovered. One afternoon we received eight casualties from a destroyer, two of whom had serious leg wounds and were actually receiving plasma by vein during the transfer between the ships. This kept me busy for a few days, but otherwise the surgical duties on a battleship are not burdensome and consist of the treatment of fractures, infections, appendicitis and now and then elective surgery such as herniorraphy and pilonidal excisions, during periods of rest and recuperation.

In May the Missouri became the flag ship of the Third Fleet and with Admiral Halsey on board we had a ring side seat for the wind up of the war. The final collapse begun on August 6 with the destruction of Hiroshima by the first atomic bomb. The ship was teeming with the news but the English liaison officer with the Third Fleet had not heard it and strolled into the Admiral's cabin to hear excited voices saying, "We have a new atomic bomb with 20,000 times the strength of T.N.T. and it was dropped on Hiroshima half an hour ago." The Britisher pricked up his ears and true to form asked, "I say, did it go off?" Well it went off all right and so did the second, and the fighting stopped so suddenly that no one knew what to do next.

Ensuing events lead to the formation of a Third Fleet landing force of sailors and marines and I found myself assigned to the marines as a battalion surgeon. Troop transports came from Okinawa and the landing force, almost 3,000 strong, was embarked from the large combat ships by breeches buoy and off we went. At dawn on August 30 we steamed into Tokyo Bay and anchored off the Yokosuka Naval Base and Air Station. The heavy ships were already in position and there was air cover from our carriers, for extra security. We took to the landing boats by climbing over the side down cargo nets, and landed at the air station and set foot on Japan about noon. Everything went off like clock work and there was absolutely no trouble from the Nips, in fact the place was deserted, except for a few Jap drivers of delapidated cars which they ran on alcohol because of the scarcity of gasoline.

The air station at first sight gave the appearance of having been deserted for a long time. The buildings were in poor repair and the machinery had been moved out. We soon found however that everything had been re-established underground. The Japs had dug extensive tunnels and caves which went for miles in the hills. There were work shops, broadcasting stations, store rooms, ammunition dumps, and even hangars underground. They were all equipped with electric lights and telephones and some even had forced ventilating systems. This

work was begun last March, when they first realized they were beaten and it was all done by hand with pick and shovel. I saw many other things dealing with war such as baka bombs and suicide subs, and also things dealing with their way of life, as for example their homes and villages and even a Buddhist Temple. At the air station we were quartered in bug ridden barracks and subsisted on K rations, so I was glad of the chance to return to the Missouri for 24 hours and be aboard for the surrender.

It was far from the pompous, colorful display of a Mikado, instead the humbled, stony delegates of the defeated Emperor, came slowly to the designated spot, led by the crippled Shigemitsu, to face the deadly serious and determined Allied commanders who stood as conquerors, mindful of the sacrifices of victory, sacrifices they would not let the aggressor soon forget. Admirals and generals were at attention in ranks to witness the closing of the war. General MacArthur appeared and with dignity and force directed the proceedings which formally and officially brought peace.

On September 5 Admiral Halsey moved his flag and the Missouri became the flag ship of Admiral Nimitz. The landing force was recalled and the next day we slipped out of Tokyo Bay to begin the long trip home to New York, by way of Guam, Pearl Harbor, the Panama Canal and Norfolk, to arrive for Navy Day, after almost a year's absence and after having steamed 105,000 miles round trip to Tokyo.

R. Starr Lampson

## From Lt. Col. John A. DePasquale, AUS, Hartford

Camp Gordon Johnston, Florida,
Station Hospital,
October 24, 1945

The JOURNAL, which has arrived regularly, has been a welcome informer. Through its well written pages I have been kept abreast of the medical problems confronted by the Society. It has enabled me to maintain knowledge of the whereabouts of many of my friends and to share their experiences with them.

I have been a member of the Armed Forces for fifty-six (56) months. My experiences to date are necessarily varied and extensive.

I entered active duty before the Pearl Harbor incident had plunged the United States into the cataclysm of world war as commanding officer of Collection Company A, Hartford, 118th Medical Regiment, 43rd Division. This regiment was commanded by Colonel Charles W. Comfort, Jr., New Haven, who was respected and loved by all ranks.

From the time of our induction until February of 1942, we underwent intensive training and I completed a course at the Medical Field Service School, Carlisle, Pennsylvania. We continued military instruction at Camp Blanding, Florida, and participated in the Louisiana and Carolina Maneuvers. The entire Division, including the Medical Battalion, was prepared by the excellent, concentrated, and strenuous training it received for the hazardous and vitally important assignments it was destined to be given in the months to come.

A great loss was suffered by the entire 43rd when Colonel Comfort, because of Army regulations pertaining to age, was relieved of his command at Camp Blanding, Florida. Esteem for this unusually capable officer had grown by leaps and bounds, as the weeks had passed. It is no exaggeration to say that his departure, which grieved his subordinates, was regarded by them as a personal tragedy.

The 43rd Division was then sent to Camp Shelby, Mississippi, where the Medical Regiment was commanded by Colonel Chester E. Haberlin, Stratford. Colonel Haberlin remained with us for just a short time. He went from us to organize and command the 21st Station Hospital, which was to see service in the European theater.

At Camp Shelby the 43rd was streamlined from a square to a triangular division. The 118th Medical Regiment became the 118th Medical Battalion, and I was assigned as its executive officer and plans and training officer. Commanding the newly designated unit was Lieutenant Colonel Charles V. Snurkowski, New Haven.

At Camp Shelby the unit completed its training and brought its equipment up to combat standards. We were finally prepared for commitment to battle and departed for the west coast. Colonel Snurkowski and I were the only Connecticut medical officers left with the Medical Battalion at this time. The others had been transferred to other units.

We passed under the Golden Gate Bridge and watched the beautiful San Francisco coastline disappear in the distance with conflicting emotions. It is a strange feeling to dwell in pleasurable and nostalgic thoughts of what one is leaving behind

when faced with the grim realities of becoming a participant in war. Most of us became mindful as never before of the values of the lives we had too frequently accepted as commonplace. We turned our eyes westward solemnly. We did not know what was in store for us.

After a long and uneventful ocean voyage, we debarked in Auckland, New Zealand. The delightful landscape between the Pacific and the Tasman Sea was beautiful grazing fields covered with "blue-green grass," the like of which I had never seen in the States. New Zealand is primarily a farm and dairy country.

New Zealand seemed far removed from war. Peace prevailed. The people, although the war had already played havoc with their domesticity and economy, were polite and hospitable. They could not do enough for us.

My visit in New Zealand was short lived. I remained there only nine (9) days. Having been selected to accompany the Division advance party, we headed up the line. From this time on, we were for all practical purposes isolated from the rest of the world. This was indeed a crucial time in Pacific and world affairs, and we were destined to come face to face with the ruthless enemy.

Although we sailed to New Caledonia through submarine infested waters, our trip was without mishap. In contrast to New Zealand, the New Caledonian landscape was rugged. It was covered with brush. Only one road led up the island, and it was a primitive route with a "wash-board" surface—an "excellent remedy" for a floating kidney.

The majority of the people were French, including the Vichy variety, and there were Kanackas, Indo Chinese, Javanese, and a host of other breeds. They lived for the most part in squalor. The sanitation of the country was deplorable. Fortunately, the Army had its own high standards, and these were adhered to rigidly. The health of the troops remained excellent.

Our medical problems on New Caledonia were nothing of unusual consequence. Despite infinite numbers of mosquitoes, malaria did not present itself. The contaminating triad, anopheles mosquito, carrier, and subject, was never complete. However, the insects were persistent and were constantly a nuisance. Welts were a familiar sight. We used mosquito repellent when it was available. We were forced to wear gloves and headnets and to spend hot and stuffy nights under mosquito netting. An outbreak of dengue fever occurred, but our movement up the line prevented its ravages from affecting us.

Subsequently we made landings on Guadalcanal, the Russell Islands, Rendova, and New Georgia. Those were dark and trying days. The horrible effects of war were apparent everywhere. Our heroic "doughboys" and gallant "combat medics" were put to acid test, and they proved themselves admirably under adverse and sometimes disheartening circumstances.

Malaria casualties increased as the days passed. Our malaria cases were of the benign tertian, p. vivax, variety, chiefly, although we had p. malariae and saw the fulminating results of p. faliciparum. Skin diseases, especially tricophytosis and pyodermia, were a common occurrence. To my knowledge, amoebic dysentery was a nonentity, and bacillary dysentery, though present, was never a serious problem.

Colonel Snurkowski finally became critically ill of malaria. He eventually became well enough to return to duty, but continued to show the effects of his illness. During his temporary absence I assumed, in addition to my regular duties, the command of the Medical Battalion. I did not feel up to par, but it was a long time before I discovered that I had been bitten by the devastating "bug."

In the frightening din of combat one ever present friend consoled all manner of men. We were all in the same boat, and we made passionate love to the same lady, Mother Earth. She was a sympathetic and comforting soul. She provided shelter from imminent death and cuddled us close to her bosom. We were grateful to her for the protection she afforded us—even though she was always unkempt, drenched with slime and mud, and unperfumed with the scent of "Chenel 5" or "Taboo." Our intimate association with the "Good Earth" was forced upon us in those days. The vicious "Sons of Heaven" had the upper hand, and there was nothing much we could do about it.

The stress and strain of war became increasingly evident. As our troops struggled through dense and sniper infested jungles, they lost weight and became sallow in appearance. Their skin was not made more attractive by the yellow tinge effected by the regular doses of atabrine administered to them.

The battle wounds were massive, destructive, and horrifying even to the medical officer. It is surprising how quickly the medical officer becomes adjusted and able to accomplish the seemingly im-

possible in such gruesome situations in spite of his limitations.

The terror and horror of the Munda campaign will remain forever in the minds of those who survived. The price paid in American lives and blood for the Munda airfield, especially by the men of our own 169th Infantry, was appalling. Major Leo Duffy, Hartford, regimental surgeon of this gallant outfit, and his medical staff, together with components from our Medical Battalion, worked indefatigably under the most trying conditions. The medical profession can justifiably be proud of their achievements and of the medical service rendered during this time of acute crisis. The medical aid men, especially, cannot be showered with enough praise. They faced death constantly to save the lives of their fallen comrades.

The evacuation of the sick and wounded during the early days of the Pacific conflict presented a major problem. Because of the exigencies of combat, troops were often scattered in small groups in isolated areas, and distances between islands were often long and hazardous. To insure early and efficient medical care in all instances, it was necessary to supplement the forward medical installations with adequate personnel and equipment.

Battalion aid stations often served as five-to-ten (5-10) bed hospitals, collecting companies as twenty-five (25) bed hospitals, and the Clearing Company as a base hospital. As no mobile surgical units were available in our area, major surgery was a common occurrence in our Clearing Company.

Evacuation from the battalion aid stations consisted chiefly of litter carry over rough and hazardous terrain to the beach or to collecting companies. The litter squads encountered sniper fire. Since the jungle terrain frequently made it impossible to use the standard Army ambulance, collecting companies used converted jeep ambulances to transport casualties to the beaches.

Evacuation from the Clearing Company was mainly by water. As soon as conditions permitted, air transportation was instituted for serious cases. Despite handicaps and difficult circumstances, the evacuation problem was satisfactorily solved and patients were moved to rear areas with the least possible delay.

I finally was evacuated and returned to the States. I was hospitalized six (6) months as a result of malaria and malnutrition. Then I was returned to duty.

I was assigned to Camp Gordon Johnston, an amphibious training center in the Florida swampland along the coast of the Gulf of Mexico. Isolation in the Pacific had prepared me for life at this installation, which is situated sixty (60) miles from "nowhere."

Colonel Chester E. Haberlin, who had just returned from the European theatre, was assigned to Camp Gordon Johnston as post surgeon and commanding officer of the Station Hospital (800 bed capacity). I was made executive officer of the hospital and chief of the Orthopedic Section. Later I was made chief of the Medical Service, and for the past thirteen (13) months I have been in command of the hospital.

Our Station Hospital is of temporary construction. However, many improvements have been made as the months have passed, and the sprawling buildings and maze-like corridors now have an attractive appearance as well as arrangement which facilitate the work of physicians, nurses, and enlisted personnel.

We have an excellent hospital staff comprised of sixteen (16) medical officers, nine (9) dental officers, seven (7) medical administration corps officers, twenty-six (26) nurses, two hundred (200) enlisted men, and six (6) Red Cross personnel. The bed capacity is at present three hundred fifty (350). Professional conferences, which are held regularly, stimulate our medical interests and keep us abreast of developments in medical research.

We have an active Reconditioning Section with educational and recreational facilities. Patients respond readily to the reconditioning program and in practically all instances are returned to duty.

Because of the isolation of Camp Gordon Johnstone and the absence of medical facilities within a radius of thirty (30) miles, civilian patients, dependents of military personnel and residents of neighboring communities who have no connection with the Army, are ever present. Our institution is not unlike a civilian general hospital. One of the chief problems our staff members must cope with incessantly is the necessity of separating the "Can't do" from the "won't do." Medical officers must not only be expert diagnosticians and therapists; often they must take on the duties of a Sherlock Holmes.

Camp Gordon Johnston recently instituted a Separation Point. As part of the process of discharging military personnel, members of the medical staff give prospective dischargees physical exam-

inations. We are attempting to achieve the objective of examining all personnel sent to us thoroughly so that records may be set straight and future complications avoided.

While the war is over, the medical profession will see its devastating effects for many years to come. The rehabilitation of our sick and wounded is a real challenge. We must be prepared to handle the situation—to expend every conceivable effort and make every necessary personal sacrifice for those who have suffered agony and been maimed to defend our democratic way of life and make permanent peace a possibility.

I take this opportunity to congratulate the Connecticut State Medical Society for its sincere and conscientious effort to preserve the noble traditions of Connecticut medicine, and to inform you that I have orders assigning me to Oliver General Hospital, Augusta, Georgia, for a course in orthopedic surgery. I send my cordial greetings to my friends and colleagues both in the Armed Forces and at home.

Johnny

## From Captain Peter G. Lehndorff, AUS, New Haven

65th Portable Surgical Hospital,
Ominato, Honshu, Japan,
October 24, 1945

I just received your letter. I should like very much to contribute to your December issue, however I haven't any particularly exciting experiences to report. Our unit, the 65th Portable Surgical Hospital has been in Hawaii, New Caledonia, Leyte, and now here in northern Honshu. In Hawaii we had some jungle training, then went to New Caledonia where we were attached to a Field Hospital. We operated a small clearing station-hospital there and did mostly medical work, but also a little surgery. I met Major Yavis, Major Abrashkin, Captain Yohn and Captain Charles Spiegel while on New Caledonia. There were some interesting medical meetings in the General Hospitals down there.

Our next station was on Leyte, P. I., where we operated as a portable hospital up in the hills, taking care of Army and Philippino patients. Now we are in Ominato, Honshu, Japan, in a position to be reasonably useful. It's a pretty isolated post, quite a ways from the nearest larger hospital. This gives us some independence and greater scope in our medical work. We operate a small station type hospital using Japanese facilities to some extent. There is particularly a fine x-ray unit. We set up a surgery, a laboratory, a pharmacy, and medical and surgical wards. We can accommodate fifty patients if necessary. We are attached to Major General P. J. Mueller's 81st Infantry "Wildcat" Division and help take care of its troops.

I am the anesthetist and internist of our group. I hope to do some work in both specialties out here before going home. Our Commanding Officer, Major Thomas M. Hadden, from Pennsylvania is an orthopedic surgeon.

Of course you've heard of Ben Biondi's work—his unit has done some excellent work in China. Jim McKeon of Hamden—in the Navy—has been somewhere in the Pacific for some time (after some interesting combat experiences in the ETO). I have an idea that our paths crossed once or twice in the Pacific but I've never been able to get in touch with him.

Kindest regards and the very best wishes for Christmas and New Years to you and to all my friends and colleagues.

Peter G. Lehndorff

## From Charles C. Montano, Senior Surgeon, USPHSR, Hartford

District Coast Guard Medical Officer
Miami 30, Florida
October 25, 1945

From this southern spot of our country, Miami, I am answering your request for a letter to be used in the December issue of the Journal. For the benefit of those who have never spent a summer in the tropics (Miami is in the torrid zone you know), may I say that the summer season in Connecticut is like child's play compared to what I have experienced here for three consecutive years. However, it is surprising how the human mechanism is capable of adapting itself to its surroundings. This has been true in my case and the past summer has not been too unpleasant accordingly.

At present, I am District Coast Guard Medical Officer of the 7th Naval District, having held this position since May of this year. The duties of a District Medical Officer are many and varied and I shall not bore you with them except to say that I

have twenty medical officers in my command. These officers are disbursed throughout the state of Florida which comprises the 7th Naval District.

Demobilization of personnel includes demobilization and disestablishment of war time medical facilities. This is no mean task and I have come to realize that it is at times more difficult to tear down an establishment than it is to build it up. Along with the above duties I have also continued to perform the surgery of those cases in this district. Needless to say, I enjoy this work more than some of the reams of paper work associated with the district office. The surgery is varied and interesting. Since the government cares also for the female dependents of Coast Guardsmen, I have also had many interesting gynecological surgical cases. Our operating room facilities are excellent and best of all completely air conditioned. We are equipped to do all types of surgery and the government has denied us nothing.

I have also had an opportunity to delve into orthopedic surgery since my stay in Miami. The cases which held a great deal of interest were those men with chronic recurrent dislocation of the shoulder. I have operated about twenty such cases in a period of two and one half years. It would seem that these cases are more prevalent in the Service than among civilians, probably due to the nature of the work performed by our men. The strenuous muscular exercise associated with rigid training programs was responsible for a good percentage of the cases. The Nicola technique with transplantation of the tendon of the long head of the biceps through the head of the humerus is, I believe, the technique of choice. I have varied the technique in a few cases. In seven of the twenty cases a portion of the fibrous capsule of the shoulder joint is also passed through the drilled bony canal of the humerus along with the tendon of the long head of the biceps. This variation in technique as suggested by Nicola produces excellent stabilization of the shoulder joint.

I have also had the opportunity to use the Roger Anderson self-aligning splint. It has proved itself to be of great value in fractures of the tibia. This method of fracture treatment is quite radical and only time will allow us to evaluate its continued use.

I, for one, am not in a position to enumerate any experiences on the fighting fronts, for I fought the war in Miami since being commissioned in 1943. However, many of the casualties were seen and treated here after their arrival in the states. It was possible for me to observe the end results in many cases. Realizing the difficulties under which many of the medical officers worked, especially in the Pacific theatre, the final results of surgery performed under trying conditions are amazing. The final results in head injuries were outstanding and made me appreciate the work done in neuro-surgery.

Setting aside things medical, may I enumerate some of my experiences witnessed in the air. I had several occasions to fly to a small Caribbean Island where the Coast Guard maintains a base, chiefly for weather reports, racon, and radar. This base is about five hundred miles due south of Miami and Cuba. These flights were most enjoyable and picturesque. The island mentioned is Grand Cayman, British West Indies and a small one at that—only a speck or dot in the vast Carribean. It is amazing how the young lads manning the Coast Guard planes can navigate to so small a place. Equally amazing, is the use of radar on these planes for locating the island. It hardly seems real. Being interested in aviation and navigation, I have read considerable on the subject. During the time that I was in the air, it gave me an excellent chance to apply some of the theory. The greatest thrill came when I was asked by the pilot if I might not like to do a little piloting. Of course I agreed. The planes used on this island hop are large PBM's with dual controls. Once in the air, these planes are not too difficult to handle. At the time I took over, we were flying at about 10,000 feet and the weather was excellent. It was a thrill I shall never forget. On this occasion I was at the controls for about one hour. On several flights following this initial experience at piloting, I also took over and needless to say, it has been a grand experience.

As you probably realize, the foremost thoughts of most medical officers at this time are home, families, private practice and being a civilian again. Many of us who have been in the Service for several years have many thoughts of the future when we realize that before long we shall once again be one of you. The uncertainty of some things in relation to re-establishing oneself to the private practice of medicine looms on the horizon before us. In your mind's eye you momentarily catch a vivid glimpse of home, your family, the little black bag, the car, the ringing phone—this makes for added courage and zest to complete the job for Uncle Sam and be on your way.

Charles C. Montano

## From Commander Charles Y. Bidgood, USNR, Hartford

October 27, 1945

I am in receipt of your letter requesting an account of some experience in the Southern Pacific. I know that you will have from other men considerable interesting medical reports and thought that perhaps you might like something of a personal nature and non-medical in character. If this does not fit in with what you want published, please do not hesitate to "scrap" it.

The following is an account of a hunting trip that I took with Major Harold Holcombe of Hartford while we were stationed at Noumea in New Caledonia.

One morning we were flown to an island about an hour's flight from Noumea, the Isle de Pins. The Army sent us down in a Cessna plane which is a two-motored ship with rather large wheels and a fairly wide tread. There is no landing field on this island so the pilot had to pick out a plateau on top of a hill to set us down.

We had a good day's hunting, and in the afternoon instead of sending a ship with the power that the Cessna has, they sent a small Fairchild training plane which has only one motor with rather small wheels with a narrow tread. The soil was rather sandy in character and there was a growth of grass of about three inches.

When we started to take off the pilot was unable to get the plane in the air, and the last time I looked at the speedometer we were doing about 72 miles per hour, were still on the ground, and running out of plateau. Finally we hit a terrific bump which knocked the plane in the air, and as we bounced off the ground the pilot pulled the stick back, and was able to stay up. He said: "This is fine, we are on our way." I said: "it is great, but unfortunately we have left one wheel on the ground." The bump had broken it off.

We had an hour to think it over, during which time we took everything in the plane that was detachable and put it on the floor. When we got over the Magenta air strip we dipped our wings and went through many gyrations to attract attention and show the ground force the trouble we were in.

Major Holcombe helped a great deal by leaning out of the fuselage and pointing to the bare axle. The pilot suggested that we jump, but not being paratroopers we did not think much of the idea. Finally the ground crew realized our difficulty and sounded general quarters. They broke out all their fire fighting equipment, including a couple of men with asbestos suits, and they had about a half dozen ambulances lined along the strip, and each of us picked out one. I chose a nice shiny one that had just been simonized. Finally, when they had all the paraphernalia correctly stationed they gave us the green light to come in. The pilot did a beautiful job. We had lost the right wheel, so he came in with the ship at an angle so that the left wheel would hit the runway first, and so slowly that I thought the plane would "pancake." The second that the wheel touched the ground he braked it sharply which tended to throw us in a ground loop to the left. Just as we started into this the bare axle touched the ground and straightened us out so that we skidded a short distance and came to a stop safely.

When we got out of the plane I said to the pilot: "Lieutenant, the least you can do is to accept some of these birds that we have shot and have a nice bird dinner," and he said: "Doctor, I don't expect to eat for a week."

Charlie Bidgood

## From Lt. Col. Margaret D. Craighill, AUS, Philadelphia

Army Service Forces,
Office of the Surgeon General,
Washington 25, D. C.,
25 October 1945

Your letter of September 10 has been held for reply until my return from a trip through the west on temporary duty with the Veterans Administration. I am at present engaged in studying the medical services available for women in veteran's facilities. With over 300,000 women veterans from this war alone, it is anticipated that there will be need for considerable expansion in the present hospitals and domiciliary facilities for women. I was glad to find that they are getting excellent care, with very good accommodations, where space is available, in Veteran Hospitals. Because of a shortage of hospital beds for all patients, women veterans are also frequently admitted to civilian hospitals on a contract basis.

My assignment in the Army has been in the Office of the Surgeon General as Consultant for Women's Health and Welfare. This involved developing policies on physical standards for women entering

the Army and their medical care during service. In doing this, I have traveled extensively in this country and spent almost nine months overseas, studying the health, living and working conditions of women in military service. The latter trip was made by air completely around the world and included every theater of war from England to China and the Philippines.

You will be interested to know that of a total of seventy-five women doctors in the Army, three came from Connecticut. The two, besides myself, are Dr. Jean Henderson from Stamford and Dr. Joyce Morris from West Hartford. The former served in several hospitals in this country before going overseas, and the latter has been on duty in the Army Institute of Pathology in Washington since she entered the Army.

I expect to be released from the Army by the first of the year to return to my position in Philadelphia as Dean of the Women's Medical College.

Margaret D. Craighill

## From Lt. Comdr. W. M. O'Connell, USNR, West Haven

United States Submarine Base
New London, Connecticut

November 2, 1945

Thank you for your letter of September 10, 1945 and let me take this opportunity to express my appreciation to you for the CONNECTICUT STATE MEDICAL JOURNAL.

I have been here at the Sub Base for the past ten months serving the capacity of surgeon-in-chief and venereal disease control office. I truly believe it has been as good an assignment as could be had in the service. Everybody works in harmony and cooperation is beyond criticism.

There has been an average of 10,000 to 12,000 men here with fifty coming and going each day, and about forty medics including dentists and medical research officers. The hospital is manned by sixteen physicians. The service covered at all times by rotating divisions. We treat everything that comes along from meningitis to fractures.

I feel I have really learned plenty. When I look back twenty-five years and think of the progress made in medical therapeutics it makes me feel good. I wonder if the young men appreciate the armamentarium they have nowadays; the fact that a g.c. can be cured in a few hours, the possible revolutionizing of the treatment of lues, and the possibilities of streptomycin are amazing.

Years ago Dr. George Blumer said the medical profession was the only profession that was continually trying to put themselves out of business. It really looks as if we might almost arrive.



Lt. Comdr. W. M. O'Connell and son

Am now anxious to resume practice and hope to see you soon in spite of the point system. Enclosed is a snapshot of my son who is in the Navy, and myself.

W. M. O'Connell

## From Lieut. D. Slossberg, USNR, Hartford

I suppose you know that I've been through the Okinawan campaign and that everything went well. My medical company did a fine job and I'm mighty proud of my men and doctors. The campaign was tough for the fighting men but not too bad for us. I lost some men both in dead and wounded. But all in all I guess we did all right.

We are now building our new division hospital so everyone is pretty busy. Our area is good, high in the hills, with beautiful valleys and fields all around. The ocean can be seen only three or four miles away. The hills are covered with pine trees. There are banana trees, lime trees and some sort of mongrel orange growing here. Of course, the sugar cane, rice and sweet potato patches abound all over the countryside. The weather is similar to Southern California.

We have a nice home—screened in—good wooden deck, tarp roof, etc. Really a swell place. Our chow is improving steadily. We are now starting to get fresh meat, potatoes, oranges, etc., occasionally.

David Slossberg

## From Colonel Joseph F. Sadusk, Jr., AUS, New Haven

Field Headquarters,
Office of Chief Surgeon
GHQ AFPAC (Advance)
APO 500 San Francisco, Calif.
30 October 1945

It is a pleasure to reply to your letter of 10 September 1945 in which you afforded me the privilege of writing and telling where I've been during the past four years of the war. It has been very interesting during this period to read the letters of others who have journeyed far and wide and I am certain that they, as well as myself, will welcome returning to a quiet and relatively sedentary life in Connecticut. My birthday, which occurs in October, has been celebrated over much of the world. In 1942, I was in Honolulu, in 1943 in Australia with Dr. Francis G. Blake, in 1944 in Holland, and finally, in 1945, I had the privilege of a final overseas celebration in Tokyo with Colonel Ashley Oughterson.

As you may recall, I entered the service in March of 1942 to receive training in tropical medicine at the Army Medical School as a member of the 39th General Hospital. In August of 1942 the War Department suddenly detached me from the Yale Unit for duty in the Hawaiian Islands. After serving in that part of the Pacific for 13 months I started back to the United States to be assigned to the Surgeon General's office but only reached San Francisco. Here I joined with Dr. Francis G. Blake and others to form a Commission to study scrub typhus (Tsutsugamushi disease) in New Guinea. This disease, encountered by our armed forces for the first time in the history of the U. S. Army, became one of the most important diseases in the Asiatic-Pacific area. Following the conclusion of our studies, which have been published in monographic form, I returned to Washington, D. C., in January of 1944 as Executive Officer for Brigadier General S. Bayne-Jones, in his capacity as director of the United States of America Typhus Commission.

In the position of Executive Officer of the Typhus Commission, I have had the privilege of close association with General Bayne-Jones and have traveled over a goodly part of the world. In the summer of 1944 I was sent over to London to assist with the organization and outline of plans for typhus control in Northwest Europe on the staff of the Supreme Commander of the Allied Forces, General Eisenhower. I returned to Washington in early winter and in early summer of the present year came out to Manila to initiate similar plans for the control of typhus in Japan in connection with coming military operations. As you well know, the sudden capitulation of the Japanese speeded up plans for dealing with health problems in the occupation of Japan. Among these problems for the coming winter, the control of typhus fever is of paramount importance and, together with my staff in Tokyo, I am now engaged in formulating broad principles for control of this disease. Surveys have already been made both in Japan and Korea and I look forward to returning to the United States by December and to Connecticut some time in 1946.

The JOURNAL has been a great boon to those of us who have been away from Connecticut; it has been our only link with old friends. I, and I am certain many others, deeply appreciate all that you have done in keeping up this association.

I am sincerely looking forward to joining you all again and spending with you many enjoyable hours discussing experiences.

Joseph F. Sadusk, Jr.

## From Captain Ulrich A. Dionne, AUS, Waterbury

November 1, 1945

I am writing this in answer to your letter of September 10, 1945. It is rather difficult for me to know just what will be of interest to the readers of



Hospital in Luxembourg castle

the JOURNAL and what will not be. I will write what I consider to be of general interest and let you be the judge as to its worth.

About 9:00 P. M., February 11, 1944, the S.S. Santa Paula with 1,200 troops on board sneaked out of New York Harbor to join a convoy of some

forty odd ships. The entire personnel of the 101st Evacuation Hospital, of which I was a member, was on board (31 medical officers, 40 nurses and about 210 enlisted men). The little ship "corkscrewed" its way gallantly across the Atlantic through stormy weather practically the whole distance, and on a dull misty day eventually arrived at Cardiff, Wales, where we disembarked.

During the succeeding five months we spent our time getting acquainted with England in general, specifically the pubs, the warm beer, the cold homes, the scarcity of food, the various civilian hospitals, the English countryside (via bicycles), the primitive plumbing and the English hospitality, which with one isolated exception as far as I was personally concerned, was above reproach.

Then came the Invasion of France. On D plus 32 we crossed the Channel and landed on the beaches of Normandie. We set up our hospital at St. Sauveur the way we thought it should be set up, and functioned as a glorified dispensary for 3rd Army headquarters for about three weeks, taking care of mine casualties, civilian and military, and various injuries among the rear echelon personnel. During this time some of us did a little visiting at the hospitals further forward, and we soon found that the arrangement of our tent hospital would have to be radically changed if we wished to handle efficiently the tremendous number of casualties that Evacuation Hospitals were expected to handle. We soon had a new plan on paper but had to wait for our next move to test its effectiveness. We did not have long to wait. The St. Lo break-through took place and we made a 200 mile move to Le Mans, where we began to treat battle casualties in earnest. Our new plan of setting up our hospital proved very efficient and practical and we adhered to that plan from then on until we went into buildings in Nancy, France, late in the following October.

It did not take us long to realize that we would all have to become adept at applying plaster casts because the greater number of casualties was made up of injuries to the extremities. We also realized that we would have to economize on rubber gloves and on gowns if we wished to keep an adequate supply available. We solved the problem by wearing the same gown all day and using one pair of gloves for two cases, scrubbing with gloves on between cases. This applied to the ordinary debridements. For abdominal, chest and brain cases, naturally we used fresh sterile gloves and gowns.

Due to the fact that after finishing Medical School I had done some work in brain surgery, by September 1944 I found myself doing neuro-surgery. My first case (a mean penetrating wound of the vertex) scared the wits out of me; fortunately for me and the patient the operation was successful and the patient was doing well when he was evacuated from the hospital. I soon settled down to serious brain surgery, acquiring skill and confidence as I went along. It was a surprise to me to find how many men survived frighteningly extensive brain injuries. The post operative deaths were very few and infection was practically nil—the latter probably due, in part, to the extensive use of penicillin and sulfa drugs. The fact that we kept our cases such a short time was disappointing from the follow-up point of view. We had no way of following them up, and could not know what the final outcome of any one case would be. I usually did two head cases in a twelve hour period, but at the end of March while we were near Mayenne, Germany, I was swamped with a backlog of nine head cases. To catch up I managed to do three cases a day, working from 8:00 A. M. to around 11:30 P. M. Unfortunately the following week I was taken sick and had to be evacuated by air to a general hospital in Paris. Subsequently I found myself on a ship bound for the states, eventually arriving at Lovell General Hospital at Fort Devens where I was retired from the service October 21, 1945.



3rd Army Band in France

As I look back I think that the Evacuation Hospitals did a remarkable job in Europe considering the conditions with which they sometimes had to put up. It was not unusual to have a backlog of one hundred casualties or more waiting for surgery, but somehow we got them through within a reasonable length of time without undue haste and with good surgical results.

An interesting sidelight I think was the rapidity with which we could get into operation after a move—the advance party (about one half the hospital) would arrive at an empty field and start putting up the hospital, and in from six to eight hours the hospital would be ready to receive patients. The hospital was a 400 bed hospital and when busy had eight operating tables going twenty-four hours a day. The surgical staff was divided into two 12 hour shifts, alternating every week. The forty nurses who were with us, most of whom were husky farm girls from the Middle West, were of tremendous help in carrying on the work of the hospital.

I could go on and on and touch on a great many interesting sidelights and details, but to do so would make too voluminous a letter. I hope that the foregoing will prove useful to you in making the Army-Navy number of the JOURNAL a success.

Ulric A. Dionne, M.D.

## From Commander Sidney A. Thompson, USNR, Greenwich

U. S. Naval Hospital,
Memphis, Tenn.,
November 5, 1945

After more than three years in service, our contemplated return to civilian life seems to offer many problems which loom like mountains before us. Most of us will find the readjustment much more complicated than we anticipate and perhaps just as difficult as was our entry into military life.

For my first year in service I was attached to the Air Force in the vicinity of Norfolk, Va., transferred to the Amphibious Force, and acted as Senior Medical Officer on an assault transport in the Pacific area from 1943 to 1945. Our primary duty was to bring in landing craft and troops to within a short distance of the beach during an invasion. After a beach head was established, casualties were returned to the ship for treatment, and on such occasions our six medical officers had more than enough to occupy themselves. During this period we participated in the invasions of Saipan, Angaur, Pelilieu, Ulithi, Leyte, Luzon, and were attached to the reserve at Okinawa, but took no active part in the latter offensive. Since July I have been on duty on the surgical staff at the U. S. Naval Hospital at Memphis, Tenn.

We are naturally all looking forward to our return to civilian life, but to date the Navy has not seen fit to return many of us to inactive duty.

Sidney A. Thompson

## From Major Clement C. Clarke, AUS, New Haven

148 General Hospital
APO 244 San Francisco
4 November 1945

What I have to say about what I am doing is a far cry from what I anticipated at this time. I was one of the many who thought the Japs would take a lot more land fighting to finish them off. And I was going to be in good spot to do some work if an invasion had been necessary.

To recapitulate: My first two years in the service, you may remember were spent with the Air Corps at McDill Field, Tampa, Fla. There I had the eye section and for a good share of the time was pretty busy with the routine stuff of getting a lot of glasses on a lot of soldiers. The normal incidence of external diseases, strabismus, and foreign bodies one finds in any similar group exercised my mere medical faculties. Just for the record it was not triplets that I delivered at McDill. I simply got stuck by a dilatory OB man when I was OD and as a result had to open the new obs ward and participate (mainly as a spectator) at the birth of the first baby at McDill.

As the training stage of the army and air corps slowed down and battened out to a maintenance program, it became obvious that there would not be much doing at McDill so I asked for and got a transfer to the ground forces. I was sent to Tuscaloosa, Alabama, to Northington GH which had just been designated as a plastic and ophthalmic surgery center. The work there was most interesting. The eye section went from 10-15 patients to over 150 in just a couple of months and I hear that it has since increased much more. Most of the patients were from the European theatre at the time I was there. The eye work was really plastic surgery about the lids and orbit for the most part. We had an excellent artificial eye laboratory there too. I was there about six months before being sent out to the Pacific. I was sorry to go in many ways, but I think I am honest in saying that I would have considered my service incomplete without some overseas time.

My overseas orders came in March '45. I was in New Haven for a couple of days before taking off. My leave was cut short as I had planned to be there about a week and get some inkling of all the plans and activities for the new hospital and other things. However, out to Camp Beale, Calif., where I paid a hello call on Col. Comfort at Creighton's sugges-

tion.

My tour of duty out here sounds more like a travelog although my travels have been pretty circumscribed since getting to the Marianas.

I followed the usual course of any casual officer: a while here in this replacement depot, then a while on detached service with an hospital there and there and there. Specifically, I went by boat from Ft. Lawton, the Seattle port, to Pearl Harbor, to 13th Replacement Depot, was attached to North Sector GH at Schofield Barracks for 5-6 weeks, then flew to Saipan via Johnston, Kwajalein, Guam and Tinian. When I landed in the Surgeon's office of course he was not looking for me, so in order to be sure not to get sent back to Guam right away, I told him I knew a lot of people in the 39 GH. Fine, says he, you go out there and have a visit until I can find a spot for you. Well, it does seem a circuitous way to get to see the friends you had left in New Haven when you headed for McDill in July '42. However it was good to see them all.

I was there at the 39th during most of June. They were still getting Okinawa patients so Pete Bishop had me assist in the OR, mostly on orthopedics. I found I could still hold a retractor or an arm, and actually enjoyed it for the short time I had to do it.

From the 39th I was finally assigned as chief EENT section over on Tinian at the 374 GH. Tinian was the biggest B-29 base of the three islands (the others being Guam and Saipan). One of the fields had four runways well over 8,000 feet long. Big medical plans were all set for Tinian. It, being more Conn. and less White Mt. than Saipan or Guam, had been picked for a large medical center. Five GH's arrived and were setting up to function as the base for the treatment of the casualties from the Empire invasion. Saipan hospitals too were being enlarged. However the unique thing about the "center" was that the five hospitals were to function as an unit under a center headquarters. Each of the hospitals was to specialize in some particular specialties much as the general hospitals in the States have specialized.

We were busy at the 374th but it was garrison work, not much from casualties. However I got pulled back to Saipan after 6 weeks to fill a hole at the 369 Station Hospital which was the earliest fixed hospital on Saipan. I had a grand time there but there was not enough work to be quite satisfied. I was over there when peace came. I learned that I had been slated to go back to the Tinian "center" for the eye job the same night that the first Jap peace proposals came out on the radio. The center and what I did, did not seem very important thereafter.

However, as the various hospitals on Saipan slowed down and ceased existence, the 369th and the 148th were left. I came over as chief EENT and maxillo-facial sections here to the 148th early in October. We still keep fairly busy in the clinic but only one ward in the hospital. Frequent jeep accidents bring in occasional face cases but most of them are orthopedic in nature.

Most of the familiar faces from the 39th have long since disappeared from Saipan to my regret but to their own great delight. New Haven should be seeing most of them by now.

None of us want to stay out here any longer than we have to, but I suppose those of us who came out later shouldn't feel too bad if we have to stay a little longer. I seem to be a middle of road-er: the point system, the age rule, the pre-Pearl Harbor rule all miss me. Even lowering the points will take too long to catch me. My best chance is on total length of service which I hope will be forthcoming soon.

From out here the problems facing the civilian medical world seem very distant. What we want is to get back and start living in "real life" once again whatever that may be. Personally I hope I can find an office and then some patients to furnish it.

Clem Clarke

## From Lt. Comdr. F. P. Guida, USNR, New Haven

U. S. Naval Hospital
U. S. Naval Training Center
Great Lakes, Illinois,
8 November 1945

I have been following the discussions of the home problems very closely, as naturally, my interest is still at home, and in the future of civilian medicine. The JOURNAL has been my chief source of this information.

As for myself, the first two years of my time in the Navy were spent in the Carribbean area, St. Thomas, V. I. and San Juan, Puerto Rico. The work was routine medical care of Marines, Navy Seabees, and Coast Guard personnel. Due to the lack of eye work available among 3,000 men there, I finally managed to get an eye clinic started among the natives at the Municipal Hospital. By the time I left,

we were drawing patients from all the surrounding islands, Tortola, St. Croix, St. John, and St. Kitts.

During March 1945, I received orders back to the States, with an assignment to the U. S. Naval Hospital at Great Lakes, Illinois. This has been in many ways an eye man's "Paradise." Due to some twist in orders, I have been left virtually in charge of the eye section. We carry approximately 100 patients on the sick list, with anywhere from 15-30 consultations a day, from other departments. There is quite a bit of surgery to be done, most of which is post-traumatic. The number of muscle imbalances that have shown up in a relatively select group, has been quite a surprise.

All in all, this has been a worthwhile experience which I shall be happy to pass on to someone else at this time.

Like everyone else, now that the war is over, I am thinking about coming home.

F. P. Guida

## THE LITTLEST ALLY

Major Russell V. Fuldner, MC—AUS, *New Haven*

When Captain Cook, the Pacific navigator, visited Tonga in 1777 he gave to Lifuka, one of the 150-odd islands of the Tongan group, the name *Friendly Island*. The name caught on the way apt nicknames do, eventually extending to all the group, and today you may address your letters to Tonga or to the Friendly Islands, as you prefer. The American armed forces, on arrival in new territory, usually develop their own place-names, names which are succinct, felicitous and unprintable. But the Yanks who landed in Tonga in the course of the recent hostilities, 165 years after Cook, found Friendly Islands a suitable enough designation. In Tonga as elsewhere in the South Pacific the Polynesians, proving the influence of climate on character, are as warm and gay as the bright sunshine which bathes their islands. Small need, to be sure, have these darlings of nature's bounty for the dour pursuit of gain, for the getting and spending which lay waste our powers. Besides, the lust for possession must be a self-limiting ailment in Tonga, since your poor relations may at any time, in limitless numbers, and for indefinite periods, share the abundance of your rooftree with you. And on a small island practically everybody is your relation, the chances are a poor one.

A hundred years ago, however, one might have concluded that Cook had gone sadly astray in naming his island. The worthy captain, indeed, may have come to the same conclusion himself, inasmuch as the natives of Lifuka wound up by attempting to murder him. The sea lanes to the South Pacific became well beaten after Cook's time, and with the introduction of civilization the Friendly Islands changed to a bloody tribal battleground. Such attributes of civilization as rum, gunpowder and a gallery of European cutthroats contributed to the disorders, nor were the natives behindhand in develing their latent talents for cannibalism, human sacrifice and ingenious methods of homicide. Yet conditions in Tonga were rather better, if anything, than in some of the neighboring island groups. The Pacific during the later eighteenth and early nineteenth centuries was a rowdy and lawless frontier, one of the world's last. Soon Europe and America, staking out their claims, were to establish police power, while the writings of men like Melville and Stevenson created a magical suggestiveness around the name of the South Seas.

Law and order ultimately returned to the Friendly Islands with the emergence of a strong king, George Tubou I. He secured his realm by conciliating those of his enemies that he could and warring on the others till they were either amenable or dead. George I established a constitutional form of government and lived to be almost a hundred. When he died in 1893 the islanders expressed their profound sense of loss by abstaining from work for several months and spending all the money in the national treasury on funeral expenses. In this pecuniary strait a treaty was concluded with Great Britain which made her the protecting power in Tonga and provided anchorage rights for British warships. Thereby was written between the lines of the treaty a considerable and in some cases a final chapter in the lives of many men yet to be born. Some of them would be born in Tonga, some in New Zealand, a few in England itself; but most of them in faraway America.

* * * *

The United States troops landing on Tongatabu, Tonga's chief island, in May of 1942 found the little kingdom readying for war. Dozens of volunteers paraded up and down daily. Several time-tested cannon—this at any rate was the rumor—had been deployed in concealed but likely spots. And in the interests of military traffic a law was passed forbidding pigs to roam the main streets of Nukualofa, the capital. Nonetheless the supplies and equipment unloaded by the Americans occasioned considerable interest among the natives, perhaps even a touch of anxiety lest their little island presently lie awash with the weight of it all. Yet, for all these formidable preparations, Tonga's bulwarks were more than a thousand miles to the north and west, the ranging carriers of Admiral Frank J. Fletcher's task force. Had the Japs broken through that line of planes and ships, all of Tonga's gallant defenders—Tongans, Americans, New Zealanders—might have been no more than so many leaves in a November gale. But even as the Americans were setting up their company areas on Tongatabu the Battle of the Coral Sea was joined, "the high tide of Japanese conquest in the Southwest Pacific," according to General Marshall. A month later, after the Battle of Midway, that tide was in ebb, though no one knew it then.

* * * *

Two soldiers of the Kingdom of Tonga gained the American decoration of the Silver Star, under circumstances described as follows in their citations:

Jione Inukiha'agana, Sergeant, South Pacific Scouts, *for gallantry in action at New Georgia, Solomon Islands, on 19 July 1943, in killing two of three Japanese who were making their way toward a wounded American soldier, and then safely evacuating the injured man under exposure to heavy enemy fire.*

Simotevea Mahe, Private, South Pacific Scouts, *for gallantry in action at New Georgia, Solomon Islands, on 10 July 1943, in killing one of three Japanese who were making their way toward a wounded American soldier, and then safely evacuating the injured man under exposure to heavy enemy fire.*

The South Pacific Scouts were graduates of a field school established in the Fiji Islands by the American command for training native volunteers in the tactics of jungle warfare. The Scouts achieved an awesome reputation in the Solomons by their skill on patrol and their facility for disposing of Japs in a variety of ways that were unorthodox but permanent. The Tongan Scouts, attached to the 37th Division, moved with their American comrades-in-arms into the Zenana beachhead of New Georgia when the action against Munda was staged. The drive for the Munda airfield was an anxious period for the Yanks, a time when the scales trembled; in such an hour America could be thankful for even the diminutive weight of her littlest ally.

According to Tongan archives, during the festivities which followed granting of their bill of rights by King George I in 1862 the islanders consumed a total of 150,000 yams and 9,000 pigs. On the momentous day some eighty years later, when Sergeant Inukiha'agana and Private Mahe were formally decorated with the Silver Star at Nukualofa, a like heartiness of hospitality prevailed. While the fare did not approach in tonnage the figures just cited, it was broadened to include chicken, turkey and lobsters. Major General Charles F. Thompson, the regional ground forces commander, flew from his headquarters in Suva to present the awards. Like everyone else at the feast he dined sitting cross-legged on the ground in the public square and slaked his thirst with coconut juice drunk from the shell. Glittering rank, both American and Empire, studded this "international occasion," as the *Fiji Times and Herald* described it, but no figure bore the air of command more effortlessly than Queen Salote Tubou, great-great-granddaughter of George Tubou I, and Tonga's reigning sovereign. Without shoes, which is how she prefers to be, the Queen stands over six feet tall. Sculptured like Demeter, she graces ermine when she chooses to wear it. At this function, still in mourning because of the death of the Prince Consort three years before, Her Majesty appeared in a black dress with an *'aofivala* tied about her waist. The *'aofivala* is a finely woven grass mat of ceremonial usage. The more ancient it is, the more estimable, and pari passu, the more tattered. In the natural order of things the Queen's *'aofivala* is about the most estimable in Tonga.

As a lyrical interlude to the pomp and splendor of that notable day in Tongan military annals, a cluster of Tongatabu's prettiest girls danced and sang songs composed especially for the event. These creatures arouse mixed thoughts in the male, thoughts perhaps of home and the actual necessity of his ever returning thither. The singing of the young ladies conveyed feeling if not comprehension to the American section of their audience. It was plain, at any rate, that the Tongans regarded the Pacific issue as settled at last. Long ago Spain, Holland and France

had wagered heavily in their bid for the Pacific, had lost out in the end. The Germans had been pushed from their holdings after the first World War. Now the Japs were gone too, gone the wily little storekeepers and the prowling fishermen, gone the free picnics and the curiously liberal credit terms they had given the Tongans. Without question the South Pacific was an American-British lake. Nor did the British pass up this happy opportunity to stress the twofold ownership: Sergeant Inukiha'agana and Private Mahe received an Empire decoration too, the Military Medal.

* * * *

Tonga is perhaps the only country in the world with a surplus in its national treasury. The annual tax is 32 shillings a head, about $5.10. Domestic help is abundant and easily lured with cigarettes and secondhand clothing. If you would like to emigrate to the Friendly Islands you may write to the Minister of Lands for information. The following random items may be of interest meanwhile:

Copra is Tonga's chief export, next are bananas. Beche-de-mer and a fungus which grows on trees are exported to China for food. The oldest inhabitant of Tonga is Tu'imalila, a tortoise supposedly brought from the Galapagos Islands by Captain Cook. Tu'imalila is tabu, or sacred, and he receives the prerogatives of a chief. A G-I who came across a girl in a remote glade complimented the woodland creature on her beautiful teeth. Her answer was simple: "I use Ipana." You will find grass mats indispensable in Tonga; you sit on them, sleep on them, wear them, hang them up for screens, and wrap your belongings in them when traveling. In the old days citizens who made themselves a nuisance were escorted out to sea, placed in badly leaking canoes and advised to just keep travelling.

The Friendly Islands have a Constitution modelled on the British system, with a Parliament, Cabinet and Privy Council. Among the natural beauties of Tonga are the blow-holes, channels in the coral reef through which the sea dashes to emerge in great fountains of spray and mist. Any who seek brief passage from this world to the next have only to step from the edge of the reef into the swirling waters. An early suspicion of servicemen that every Tongan was a profiteer abated when it turned out that the only American word many of the natives knew was "dollar." Pigs, the chief livestock of Tonga, have been the subject of repeated legislation. According to one ordinance the finder of a dead pig may claim the carcass only if two hours of diligent search fails to locate the owner. Occasional slave raids took place in the old days, and some negro G-I's claimed to have found kin on Tonga. One island in the group has a habit of sinking into the sea. When it over to assert Tongan sovereignty before a foreign power claims it.

Tuberculosis causes about a quarter of all deaths in Tonga. The disease was probably unknown to the South Seas before the coming of the white man; an idle but widespread slander is that Robert Louis Stevenson introduced it. Polynesian dances are likely to be of a quite different species from those in your local Hawaiian Cafe; the dancers wear long Mother Hubbards beneath their grass skirts and many of their dances are performed in the sitting position. The practice of human sacrifice underwent gradual replacement by the token sacrifice of fingers. Old people with fingers amputated to propitiate the gods were to be seen until quite recently. A patient going to the hospital in Tonga must provide his own bedding, nurses and meals. He is not required to assist at his operation.

* * * *

In the Friendly Islands a certain lightness of the air is likely to catch the spirit and set it afloat. Stretched on the warm shore you find your thoughts skipping across the water like a flung pebble, tumbling over the far edge of the horizon. To the north lies Samoa, beloved of Stevenson. The Samoans returned his love in ample measure; they called him Tusitala, Teller of Tales, and carried his body up the difficult slopes of Mount Vaea to its last resting place. Far to the east is Tahiti, where Gauguin's genius came to a strange and brilliant florescence. Suva, hub of British Oceania, some four hundred miles west, is distant enough that the seaways and airways of the world pass the Friendly Islands forever by. Fortunately your imagination is free today as the sunlight which catches now one wave-crest, now the next, else you might take Tonga for no more than a plain sister in a bevy of belles. But we have the word of all the tellers of tales, ancient and modern, that the plain sister is destined for the greatest fortune in the end. Quite right they are, for to Tonga has fallen a superlative portion of rare gifts. May she always retain them, these treasures of friendliness and hospitality; the world's stock is low, even running out. Future voyagers may need to seek them here again. High fortune, Friendly Islands, to be the goal of man's unending search:

*On such a sea as this Ulysses sailed*
*when he sought the Happy Isles.*

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### Society to Entertain President Roger I. Lee

December 13 is an important date for members our our Society to check on the calendar. On that day in addition to meetings having to do with the affairs of the Society we will entertain at a dinner meeting. The President of the American Medical Association, Dr. Roger I. Lee of Boston and the Editor of the Journal of the Association, Dr. Morris Fishbein of Chicago. Our members should not need to be reminded that our State Society through its representatives occupies an enviable position in the affairs of the national organization. To support that position and these men means that each of us must make every effort to attend this truly significant occasion. In addition to these guests others to be honored will be the Council of The New England Medical Societies.

This is our first Society get-together for many months and at this time we will also welcome many of our returned medical officers. Obey that impulse by making reservation NOW.

The program for the day follows.

1:00 P. M. Council luncheon followed by executive meeting.

3:00 P. M. Semi-annual meeting, House of Delegates; Reports from President and Chairman of Council. The Council of New England Medical Societies will be the guests of the House.

5:30 P. M. Reception by House of Delegates for Guests of the Society.

7:00 P. M. DINNER MEETING, President J. H. Howard, Presiding.

*Speakers*

Mrs. James R. Miller
President of Woman's Auxiliary

John T. Kenny, President
Rhode Island Medical Society

Roger I. Lee, President
American Medical Association

Morris Fishbein, Editor
Journal of the American Medical Association

## The Army and Navy Number

In this our third Army and Navy issue we again salute those Connecticut physicians who, at the call of civic duty, entered our country's service. As the JOURNAL goes to its readers this month, most of our medical officers are still in active service, but each succeeding week now sees more and more of our doctors returning to civil life and civilian practice. To these latter the Connecticut State Medical Society extends a hearty welcome home. Through its administrative offices the Society is endeavoring to use every opportunity to aid these men in their return to medical practice. Our readers will be pleased to learn that in this field of activity our Society has assumed, we are informed, a leading and pioneer role.

To those of our members whom this issue finds still in service the JOURNAL through its editors sends a sincere Christmas and New Year greeting with the hope that the time is not far distant when they too will be coming back to the "land of steady habits." To this greeting we add a word about the affairs of the Society which is gratifying. Many things have happened in the preceding year which mark a distinct progress. Among these may be mentioned the prepayment medical service plan which will soon be inaugurated, the success of the Building Fund campaign which assures the Society of a permanent home, the important development of the Woman's Auxiliary, and the increasing part which the Society and its members are taking in various State activities having to do with public welfare, to mention but a few. The list is a long one, but these and other accomplishments have been possible only because of the interest and selflessness of our members when called upon for such service.

The communications which we are pleased to publish in this number show the same interest and enthusiasm which marked similar previous issues. They speak for themselves and, to those who have so contributed, we express our gratitude for the thoughtfulness which prompted them to share with us the richness of their experience.

## Service For Returned Medical Officers

Well over one hundred returning medical officers have been in the Society's offices for interview. The questions they present are diverse and interesting. In general, most Connecticut veterans expect to return to the communities which they left and resume their practices. Some want to discuss the extension of their education before going back into practice and a few seek a change of location.

Up to the present there has been difficulty in locating veteran medical officers who wish hospital residencies and fellowships. This is because most of the desirable appointments of that kind are already filled by deferred residents or persons physically disqualified for military service. It is hoped that the new Procurement and Assignment Service directive ending all service deferments on April 1, 1946, or soon thereafter, will make available an increasing and adequate number of residencies for returning medical officers.

Many veterans from other states have visited the Society's Service Bureau seeking information concerning licensure to practice in Connecticut and locations for practice.

Several weeks ago the Secretary's office made a survey of the state and inquiries were sent to nearly one hundred sources seeking data concerning the need for medical personnel in addition to Connecticut physicians who are expected to return from military service. The facts obtained from this study are most valuable and based upon them it is possible to advise new physicians seeking locations in Connecticut to locate in areas where their services are believed to be needed.

The uprooting of so many physicians as a result of the war has caused such widespread changes that medical practice and the distribution of physicians will not be stabilized for a long time. Already it can be noted that more than fifteen per cent of the physicians who left Connecticut to go to war do not plan to return here after their discharge. This proportion seems high, perhaps it will lessen as time goes on. If it does not, there will be many gaps left in medical care in several Connecticut communities. The Service Bureau for medical officers is endeavoring to keep this confused state of affairs in balance and to be of every possible service to members of the Society when they return to civil life.

## What It All Costs

The annual report of the Comptroller of the State to the Governor is a public document of more than passing interest and one that merits far wider attention than is accorded it. Here is the accounting to the people of Connecticut of the disposition of the public funds provided by them for the execution by the state government of the duties and responsibilities with which it is charged.

Revenues and expenditures for the fiscal year are classified, insofar as is practicable, as to budgeted agencies, sources of funds, functions, objects, character and activities and the resulting statements are clear and readily comprehensible. Yet this record of the financial transactions and financial condition of the state, which should be the concern of every citizen, is in all likelihood entirely unfamiliar to all but a few hundreds of persons.

A detailed analysis of the Comptroller's report is not feasible and probably not desirable in the pages of the JOURNAL. Certain sections, however, in particular those dealing with expenditures for health and welfare, are of major import to the people of the state and especially to the medical profession and allied fields.

Under Schedule Number 10, which presents a tabulation of the net expenditures of the general fund for the year ending June 30, 1945, the funds which were spent in "Conservation of Health and Sanitation" are classified according to ordinary recurring expenses; fixed charges, grants and donations; capital outlay; and totals. For present purposes, sufficient information is provided by the following total entries.

CONSERVATION OF HEALTH AND SANITATION

| | TOTAL |
|---|---|
| State Department of Health | $676,457.79 |
| Food Regulation and Inspection | 473,513.01 |
| Total—Conservation of Health and Sanitation | $1,149,970.80 |

Disbursements of the state for other health, social and welfare services are listed under the title "Charities, Hospitals and Corrections and it is evident, again citing totals only, that a very substantial part of the state's monetary resources are allotted in these categories.

CHARITIES, HOSPITALS AND CORRECTIONS

| | |
|---|---|
| Total Administrative Costs (includes Division of Public Assistance) | $ 3,126,748.13 |
| Care of Children (Division of Child Welfare, Newington Home for Crippled Children and County Homes) | 1,210,773.84 |
| Care of Blind, Deaf and Mute | 362,839.77 |
| Other Charities (excluding aid to Indians) | 66,293.78 |
| Care and Treatment of the Mentally Ill | 3,651,660.05 |
| Care and Treatment of the Tubercular | 2,203,621.10 |
| Care of Veterans | 750,256.12 |
| Care of Feeble Minded and Epileptic | 1,422,863.76 |
| State Aid to General Hospitals | 393,945.14 |

The State of Connecticut spent $1,624,101.94 during the fiscal year on its correctional institutions, that is, the Connecticut State Prison, the State Farm for Women, Connecticut Reformatory, Connecticut School for Boys and Long Lane School. The position that this also is essentially a medical expenditure is a defensible one, however, in computing here the outlay of funds in this category, it has been deducted, with a resulting total of $13,189,001.69. When this figure is combined with the total for Conservation of Health and Sanitation, it is found that Connecticut, in the twelve month period preceding the Comptroller's report, spent $14,338,972.49 on health, medical care and treatment, including hospitalization, and welfare. This sum assumes added significance when it is realized that it constitutes 43 per cent of the overall general fund expenditures of $33,311,053.80.

Appropriations for medical care, public health and social srevices have been steadily increased in our state, often as a consequence of thorough and conscientious studies and surveys of particular problems. Two such investigations which are especially noteworthy are even now under way: the study of the care of the chronically aged, ill and infirm; and the study of the control of alcoholism. It may be expected that the recommendations of the commissions directing these important investigations will result in additional appropriations and far-reaching new programs for the people of this progressive and health state.

## The Building Fund Grows Yet More

Contributions continue to come in for the new home for the State Medical Society, as is evidenced by the additional list of subscribers published in this issue. It is very gratifying to the Trustees of the Building Fund to see the names of more and more of our members added to this list. It is their hope that all will want to have a share in this project. The letters being received from members in the Armed Forces give expression to the interest of the writers in the future practice of medicine in their home State of Connecticut. No finer method can be found of expressing our desire to uphold the efforts of our State Society officers in maintaining the highest standards of medical practice than in the realization of a suitable home in which the Society may carry on. No more tangible evidence of appreciation of the accomplishments of organized medicine

in Connecticut can be found than by a contribution to the Building Fund.

There is a mistaken idea held by some that the Society is about to embark upon a building program of such magnitude that it will be extending its benevolence to organizations of a kindred nature in our State. No purpose is further from the minds of the Trustees. In order to acquire or build a structure of sufficient size to house all of our departments and at the same time provide for expansion which must occur in the future, it will be necessary to have a building containing more actual room at the onset than is needed by the Society at the present time. It is proposed to rent this space to certain organizations which have much in common with ours only until such time as the Society shall need the space for itself. That such a day will come must be apparent to anyone who takes notice of the record of growth of our Society during the past two decades.

Other objections have been raised, chiefly because of misunderstanding. Let us not lose sight of the need. By our gifts we shall help the Trustees of the Building Fund to crystallize their plans. There is yet time for you to contribute.

## Optimum Nutrition For Connecticut Children

Among the many lessons which are to be learned from the findings of medical examinations of the Selective Service, none is more significant or important than that having to do with human nutrition. That it is possible to bring fundamental nutrition benefits to a great number of our population is shown by the great improvement of draftees under service feeding and exercise. For the entire nation, however, there is today no greater field for similar benefit than in that of the school child—the citizen of tomorrow. The problem, however, is not one simply of the school, but requires the coordinated efforts of the school, home, community, and state. The necessity of legislation on the state level to bring these influences together has been recognized recently by the State of Oregon to the effect that by legislative requirement health curricula in all elementary and high schools of the state must be planned to include: (1) personal hygiene; (2) community health and sanitation; (3) communicable diseases; (4) nutrition; (5) mental health; (6) safety education; (7) first aid; (8) choice and use of health services and health products; (9) physiology of exercise; (10) structure and functions of the human body; and (11) effect of alcoholic drinks, stimulants and narcotics. This program has nothing to do with recreation or interscholastic sports. The legislation itself is mandatory rather than permissive with regard to public schools. It brings together in cooperative effort the State Departments of Health and Education, representatives of the State Medical and Dental Societies, nutritionists, teacher and parent groups to form a State Joint Committee. This group is the policy forming, planning and administrative body behind the Oregon plan. In commenting on the Oregon program, Dean Leighton of the University of Oregon says: "It shall be the purpose of these programs to promote, develop and maintain among pupils at all age levels optimum physical growth, health and physical fitness." At a recent meeting members of the Hezekiah Beardsley Pediatric Club discussed the plan and emphasized the importance of a similar plan for Connecticut, pointing out in addition that the parents of young, growing children in too many instances do not appreciate the fundamental value of nutrition in their own homes and that, not only in these groups but in obstetrics and geriatrics, proper nutrition is often a major problem.

The part that the physicians of our state could assume in bringing the importance of this kind of legislation to the attention of our law makers is significant, for much of the wise health legislation now on our statute books had its beginnings in the minds of our profession. The Oregon plan of attack warrants careful consideration, for it emphasizes the real and lasting benefits that can come to a state people through local responsibility and cooperative action, a system deep in the hearts of Connecticut citizens since the beginning of our commonwealth.

## Clarifying the Narcotic and Hypnotic Law

Some confusion and considerable dissatisfaction seems to have arisen on the part of physicians over the operation of Section 603h-604h of the Revised Statutes under the passage of H.B. 1026 of the 1945 General Assembly. In attempting to live up to the letter of the law which requires that the pharmacist shall not refill prescriptions containing certain drugs "except upon the written or oral order of the physician," the pharmacist has been treated without the consideration due him by the physician. Granted that it is a nuisance to be called on the phone for permission to refill a prescription, if the physician will carefully read the law here appended he will see that his fellow pharmacist has no other recourse (except the more annoying one of requiring the

prescription for refill in writing) if he is to protect himself from penalty. The pharmacists are to be commended for their adherence to the rules of the game. We as physicians should realize that the welfare of the patient is at stake and should assist the pharmacist in enforcing the law by courteously granting the requested permission, if such is indicated. It has been suggested by the secretary of the Board of Pharmacy Commissioners that physicians write prescriptions for a sufficient supply of the drug for one month and mark the prescription "NR" (non repatatur), or "Fill as needed." In the former instance the patient should be instructed to return to the physician at the expiration of the month.

The law reads as follows:

Section 1. Subsection (d) of section 901e of the 1939 supplement to the general statutes is repealed and the following is substituted in lieu thereof: If it shall be for use by man and shall contain any quantity of the narcotic or hypnotic substance alphaeucaine, (barbituric acid,) betaeucaine, bromal, cannabis, carbromal, chloral, coca, cocaine, codeine, heroin, marihuana, morphine, opium, paraldehyde, peyote or sulphonmethane; or any chemical derivative of any such substance, which derivative has been designated as habit forming by regulations promulgated under section 502(d) of the federal act; unless its label shall bear the name and quantity or proportion of such substance or derivative and in juxtaposition therewith the statement "Warning—May be habit forming."

*No such prescription shall be refilled except upon written or oral order of the physician.*

Sec. 2. Subsection (k) of said section 901e is repealed and the following is substituted in lieu thereof: If it shall be a drug sold at retail for use by man and shall contain any quantity of amidopyrine, barbituric acid, cinchophen, dinitrophenol, sulfanilamide, or any derivative of any of these substances, unless it shall be sold on a written prescription signed by a member of the medical, dental or veterinary profession who is licensed by law to administer such drug, and its label shall bear the name and place of business of the seller, the serial number and date of such prescription and the name of such member of the medical, dental or veterinary profession.

Sec. 3. Section 902e of said supplement is repealed and the following is substituted in lieu thereof: A drug dispensed on a written prescription signed by a physician, dentist or veterinarian, except a drug dispensed in the course of the conduct of a business of dispensing drugs pursuant to diagnosis by mail, shall: If (1) such physician, dentist or veterinarian shall be licensed by law to administer such drugs and (2) such drugs shall bear a label containing the name and place of business of the dispenser, the serial number and date of such prescription and the name of such physician, dentist or veterinarian, be exempt from the requirements of section 901e.

*Except that no prescription for amidopyrine, barbituric acid, cinchophen, dinitrophenol or sulfanilamide or any derivative of any of these substances shall be refilled except upon the order of the physician.*

## Healthful Connecticut

Connecticut heads the "Group I-Excellent" class of states in a health rating by Louis I. Dublin, vice-president and statistician of the Metropolitan Life Insurance Company, which appears in the current *American Magazine*. The rating was arrived at by combining six factors, including the general death rate, infant mortality rate, death rate from tuberculosis, rejection rate for selectees, and the ratios of physicians in active practice and hospital beds to the population. The other ten states in the top group are, in the rating order, Minnesota, Nebraska, Oregon, Kansas, Iowa, Wisconsin, Utah, North Dakota, Massachusetts and New York.

Notable health achievements during World War II, in addition to the extraordinarily good health of the armed forces, are described thus: Life expectation reached a peak just short of 65 years, the tuberculosis death rate continued to decline, the mortality of mothers and infants was sharply reduced, the line was held against the respiratory diseases—in contrast with World War I when a devastating epidemic of influenza and pneumonia cost more than 500,000 lives, child health reached a new high of excellence, the civilian accident record was satisfactory and the industrial accident level continued low, despite the enormous increase in production, and suicides declined more than 20 per cent, reflecting good general morale.

This is a gratifying record, the more so when we consider the strains and dislocations of four war years. From the national standpoint, a disturbing thing is the extremely wide variations in health conditions as between the various sections and states. There is still large room for progress, especially in the fourteen states of the "Group IV-Poor" class, all of which are south of the Mason and Dixon line.

*New Haven Journal Courier*

# THE PRESIDENT'S PAGE

## YOUR STATE SOCIETY

It is the custom that twice each year the President, Chairman of the Council, and the Executive Secretary visit each County Society and report on the activities of the parent organization. For many years this was accomplished with satisfaction to the members of the eight counties. However, the tempo of life has changed, and with it the problems that have arisen which demand constant attention of the Council and the various counties of the Society.

The time allotted at a County meeting is not sufficient to review in detail the ever increasing problems confronting the medical profession without encroaching upon the period devoted to important business of local interest. The officers and members of the Council are trying to keep abreast of these various problems. It is only by their sacrifice of time and energy, their zeal for improved medical care, and their sense of responsibility to their colleagues who have placed them in these important offices, that satisfactory progress is being made in the development of an efficient and sound organization.

Reports of these various activities are published in your Journal each month and a message is carried to your County each Spring and Fall. It is regrettable that many do not read that portion of the Journal dealing with these reports, and it is also unfortunate that the semi-annual report of the officers is heard by only ten per cent of the county members.

The desire of the officers and Council is to stimulate interest in your Society which can be done if every member is entirely familiar with all of the progressive actions approved by your representatives. The office of the State Society is your office. Visit it; discuss your problems with our very efficient Executive Secretary.

The plan of dealing with discharged medical veterans, as developed by Dr. Barker, is being used as a pattern throughout the country. We, therefore, urge physicians, as soon as they are discharged from the armed forces, to visit Dr. Barker for advice and counsel.

Should a local medical society, a county group, or a hospital staff care to discuss a problem in which the officers of our Council can be of help, they are at your service.

Remember, it is your State Society.

Joseph H. Howard, M.D.

## The Approach to the Patient

From a George W. Gay Lecture on Medical Ethics, presented at the Harvard Medical School, May 15, 1945, and published in *The New England Journal of Medicine*, October 11, 1945.

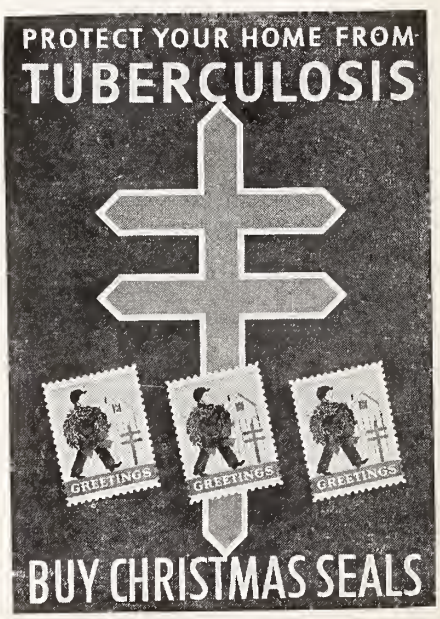
No less a person than the novelist Ben Ames Williams, admirer of psychopathic heroines, is responsible for the reminder that physicians do not sufficiently realize the fact that their patients are frightened, that they as physicians do not pay enough attention to a study of the emotions, and that to be successful they should supplement their professional competence with what salesmen call a good approach. Whether or not all patients are psychoneurotic as this novelist would have us believe, he is unquestionably correct when he states that a physician is a better physician if at some previous time he has been ill himself. The author of "The Strange Woman" would have all medical schools introduce into the curriculum a course of lectures given by patients. We are quite certain this would create a commotion, even greater than the admission of women medical students to Harvard. Whether or not the embryo physician would benefit from such an experiment is a question.

The specialist is reminded that, more than the family physician, it is he who arouses fear within his patient. Specialization is likened to industry with its production line. "The human chassis, on a belt conveyor, passes under the eyes of a regiment of specialists, and one does this and another does that, each restricting himself to his particular field. And as though the mechanic who affixed the bumper thought he had built the car, each doctor when the patient recovers may secretly assure himself that he and he alone accomplished the cure. For the specialist tends to find in his own specialty the source of every human ill. To the dentist, it is the teeth; to the oculist, it is the eye; to the gastroenterologist, the stomach; to the cardiologist, the heart. Just as the successful businessman comes to think of his very own business—the manufacture of some particular soft drink, the production of rivets, the distilling of alcohol—as the foundation of our economic structure, so the specialist may come to believe that in his field lies every healing virtue."

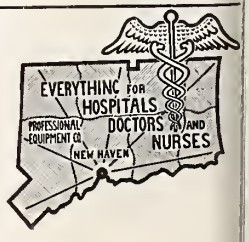
## Tuberculosis Death Rate of Twenty Predicted for 1960

Only 20 people in every 100,000 in the United States will die from tuberculosis in 1960 if the present rate of improvement continues, statisticians of the Metropolitan Life Insurance Company estimate. At present, about 40 in every 100,000 die from tuberculosis, while in 1921 about 100 per 100,000 died from this disease, which caused the death of almost 200 in every 100,000 at the beginning of the century, according to the U. S. Bureau of the Census. For more than four decades, the mortality from tuberculosis in our country has been decreasing without interruption. The current death rate from the disease is only about one-fifth of what it was in 1900.

From 1921 through 1943, the death rate decreased on an average by 4 per cent annually. This means that the absolute annual decline was less each year, but it should be remembered that as room for improvement diminishes, it becomes increasingly difficult to make further gains.




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(SEE PAGE 2)

# *DINNER MEETING*

OF

# THE CONNECTICUT STATE MEDICAL SOCIETY

NEW HAVEN LAWN CLUB 193 WHITNEY AVENUE

THURSDAY, DECEMBER 13, 1945, 7:00 P. M.

MEMBERS OF THE WOMAN'S AUXILIARY ARE CORDIALLY INVITED TO ATTEND

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PROGRAM

Joseph H. Howard, President of the Society

Mrs. James Raglan Miller, President, Woman's Auxiliary to the Society

John F. Kenney, President, Rhode Island Medical Society

Roger I. Lee, President, American Medical Association

"Timeo Danaos Dona Ferentes"

Morris Fishbein, Editor, Journal of the American Medical Association

"Medicine in the Post War World"

Informal dress

# MEMBERS OF THE CONNECTICUT STATE MEDICAL SOCIETY IN THE ARMED FORCES OF THE UNITED STATES

A—Army, N—Navy, PH—Public Health Service *Separated from Service †Deceased

## FAIRFIELD COUNTY

*BETHEL*

*GRIGAS, JOHN E. (N)
WOLFSON, DEXTER L. (A)

*BRIDGEPORT*

*ALPERT, MAX A. (A)
ANTELL, MAXWELL J. (A)
BAKUNIN, MAURICE L. (A)
BELLEW, RAYMOND F. (N)
BRIER, HYMAN D. (A)
*BUCKHOUT, GEORGE A. (A)
*BUCKLEY, JOHN (PH)
CACACE, VINCENT A. (N)
*CASTALDO, LOUIS F. (A)
CLARK, WILLIAM T. (A)
*CONNORS. EDWIN R. (A)
DONNELLY, WILLIAM A. (A)
DUZMATI, PAUL P. (A)
EDDY, MAXON H. (N)
ESPOSITO, JOSEPH J. (N)
GEER, WILLIAM A. (A)
*GREENSPUN, DAVID S. (A)
GULASH, JOHN R. (N)
HARDENBERGH, DANIEL B. (A)
HARPER, PAUL (A)
HORN, BENJAMIN (A)
HURLBURT, EDWARD G. (N)
KEYS, ROBERT C. (A)
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*MASSEY, DANIEL A. (A)
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MONAHAN, DAVID T. (A)
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POPKIN, MICHAEL S. (A)
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*SIMSES, JOHN P. (A)
*SOLLOSY, ALEXANDER (A)
*SPINELLI, NICHOLAS (A)
STRAYER, LUTHER M., JR. (A)
*UNGER, MILTON (N)
UVITSKY, IRVING H. (A)
*WARD, JAMES P. (N)
ZAUR, I. SIDNEY (A)

*COS COB*

AYRES, PAYSON B. (N)

*DANBURY*

AMOS, ISADORE J. (A)
DE KLYN, WARD B. (A)
*ECKERT, GEORGE R. (A)
GAFFNEY, JOHN J. (A)
GIBSON, DONALD F. (N)
GOLDYS, FRANK M. (A)
ROGOL, LOUIS (A)

*DARIEN*

MOORE, GILBERT F. (A)

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*PITOCK, MORRIS P. (A)
*VERSTANDIG, CHARLES C. (A)

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CRAIGHILL, MARGARET (A)
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*MOORE, CLIFFORD D. (PH)

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WEINSTEIN, NATHAN (A)

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†HEIDGER, LUTHER C. (A)
PENNER, SIDNEY L. (A)

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*ELLRICH, DAVID (A)
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KELSEY, WESTON (A)
NESPOR, ROBERT W. (N)
PHILLIPS, HARRY (A)

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*STEVENSON, WILLIAM R. (A)
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VOGEL, S. FRANK (PH)

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TRANTOLO, ARTHUR (A)

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*LEWIS, SAMUEL D. (A)

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EWELL, JOHN W. (A)

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BIRGE, HENRY L. (A)
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*DUFFY, LEO T. (A)
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GUDGER, JAMES R. (N)
*HALL, WENDELL C. (A)
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HAYMAN, MAX (A)
HAZEN, DONALD (N)
*HENNESSEY, JAMES J. (N)
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LANKIN, JOSEPH J. (A)
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*LOWELL, W. HOLBROOK, JR., (A)
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McLELLAN, PHILIP G. (N)
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*MONTANO, ROCCO A. (A)
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MURPHY, THOMAS F. (PH)
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PERKINS, JOSEPH A. (A)
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ROGERS, FREDERICK P. (N)
ROMANIELLO, ROCCO J. (N)
ROSENBAUM, GEORGE J. (N)
RYAN, FRANCIS J. (A)
SABLOFF, JACK (A)
SAMPANARO, NICHOLAS (N)
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*SCOVILLE, WILLIAM B. (A)
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SHULMAN, DAVID N. (N)
SHUPIS, ANTHONY J., JR. (A)
*SILVER, GERSHON B. (A)
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SMITH, WILSON F. (A)
SNEIDMAN, GEORGE I. (A)
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SPONZO, JAMES J. (N)
STANDISH, WELLES A. (N)
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*TOMBARI, SERAFINO (A)
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*TOVELL, RALPH M. (A)
*TOWNSEND, WILMOT C. (A)
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*UNSWORTH, ARTHUR C. (A)
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WEISENFELD, NATHAN (A)
WHITCOMB, BENJAMIN B. (A)
WHITE, BENJAMIN V. (N)
WILSON, ARCHIBALD C. (N)
WILSON, WILLIAM A. (N)
WINTERS, JOHN T. (N)
ZARIPHES, CONSTANTINE (A)

*KENSINGTON*
*LO VETERE, A. ARTHUR (A)

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CONLON, WILLIAM L. (N)
*DISKAN, A. ELMER (A)
KEENEY, ROBERT R., JR. (A)
*SUNDQUIST, ALFRED B. (A)
ZAGLIO, EDMOND R. (A)

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*KRASZEWSKI, HENRY W. (A)
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MICHALOWSKI, VALERIAN S. (A)
*MILLER, HARRY B. (A)
*NEVULIS, ANTHONY V. (A)
PERAKOS, GEORGE PETER (A)
POLA, WILLIAM E. (A)
PULLEN, RICHARD W. (A)
SCULLY, ROGER T. (N)
TRAPP, FRANCIS W. (N)
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WHITE, JOHN C. (N)

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*PLAINVILLE*
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GREENE, GERALD G. (N)
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*COATES, STEPHEN P. (A)

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*JOHNSON, PAUL (PH)
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*SHULL, JOHN C. (N)
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*SULLIVAN, ARTHUR B. (A)
TAIT, ARTHUR A. (A)
WILSON, A. C. (N)

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*SMITH, WILLIAM B. (A)

*WINDSOR*
MONACELLA, JOHN M. (A)

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SELLEW, ROBERT C., JR. (A)

*CORNWALL*
*WALKER, ROBERT (A)

*LITCHFIELD*
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WRAY, EDWARD H., JR. (N)

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*LA TAIF, C. GEORGE (A)

*NORTH WOODBURY*
MARKLE, RAYMOND D. (A)

*TORRINGTON*
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*KENNEDY, W. CLEMENT (A)
*KOTT, JOSEPH H. (A)
MURCKO, WILLIAM J. (A)
ORLOWSKI, ANDREW W. (N)
SUTHERLAND, FRANCIS A. (A)

*WATERTOWN*
†REICHENBACH, FRANK (N)
*MYERS, ROYAL A. (A)

*WINSTED*
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CORNELIO, FRANCIS J. (A)
GALLO, FRANCIS (A)
LEVY, AARON (A)
SANDERSON, ROY V. (N)

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*RINDGE, NORMAN P. (A)

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TATE, WILLIAM J. (A)

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HANSEN, PAUL S. (A)

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*JOYCE, WILLIAM M. (A)
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SIMON, BENJAMIN (A)

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*RYAN, VINCENT GERARD (PH)

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WAGNER, HERBERT T. (PH)

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*CENTRONE, PATRICK (A)
*CLAIBORN, LOUIE E. (A)
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*CONTE, MARIO (PH)
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*DAVIS, JACHIN B. (A)
D'ESOPO, JOSEPH (A)
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FEYDER, SIDNEY (A)
*FIORITO, JOSEPH A. (A)
FLYNN, HAROLD A. (A)
*FOX, JAMES C. (A)
FRIEDMAN, IRVING (A)

FULDNER, RUSSELL V. (A)
GAROFALO, MARIO L. (A)
GENDEL, BENJAMIN R. (A)
*GENTILE, ANGELO L. (A)
GERMAN, WILLIAM JOHN (N)
GRANOFF, MORRIS A. (A)
GUIDA, FRANCIS P. (N)
HARRIS, BENEDICT R. (N)
HATHAWAY, JOHN S. (A)
HAVILL, RUPERT A. (N)
*HESS, ORVAN A. (A)
HOFF, EBBE C. (N)
*JAFFE, SAMUEL A. (PH)
JORDAN, ROBERT H. (A)
KIRBY, SAMUEL B. (A)
KLATSKIN, GERALD (A)
KLEBANOFF, HARRY E. (A)
KOUFMAN, WILLIAM B. (A)
*KROSNICK, GERALD (A)
*KROSNICK, MORRIS Y. (A)
LAUBE, PAUL J. (A)
LAVIETES, PAUL H. (A)
LEHNDORFF, PETER (A)
LINDSKOG, GUSTAF E. (N)
*LOGAN, WILLIAM J. (N)
LUTZ, WALTER G. (A)
*MAYNARD, HARRY H. (A)
*McCABE, EDWARD J. (N)
*McDONNELL, RALPH E. (PH)
MERRIMAN, HENRY (A)
MIGNONE, JOSEPH (N)
MOORE, DONALD B. (N)
*MOTT, FREDERICK E. (A)
NESBIT, SAMUEL (N)
*NODELMAN, JACOB (N)
O'CONNOR, DENIS S. (N)
OUGHTERSON, ASHLEY W. (A)
PELTZ, WILLIAM L. (A)
PERHAM, WILLIAM S. (A)
*PICCOLO, PASQUALE A. (A)
PINN, ABRAHAM S. (A)
†PURPLE, MAYO R. (A)
RADEMACHER, EVERETT S. (PH)
REDLICH, FREDERICK C. (A)
*ROBBINS, CLARENCE L. (A)
*ROBERTS, FREDERICK (N)
ROTH, OSCAR (A)
ROZEN, ALAN A. (A)
*RUBIN, GEORGE A. (A)
SACHS, KURT (A)
SADUSK, JOSEPH F., JR. (A)
SHAFFER, THOMAS F. (A)
SHURE, A. LEWIS (A)
SINCLAIR, SIDNEY (N)
SMITH, FRED F. (A)
SNURKOWSKI, CHARLES V. (A)
*SPERANDEO, ANTHONY (A)
SPIEGEL, CHARLES M. (A)
SPINNER, SAMUEL (A)
*STEVENS, MARVIN A. (N)
THOMPSON, LLOYD J. (A)
*THORNE, LEWIS (A)
VERMOOTEN, VINCENT (A)
WELT, LOUIS G. (A)
*WENTWORTH, JOHN H. (A)
*WIES, FREDERICK A. (A)
WILSON, WILLIAM R. (N)
WOODRUFF, LORANDE M., JR. (N)
YAVIS, JOHN C. (A)
ZAFF, FRED (A)
ZIMMERMAN, H. M. (N)

*New Haven Out of County*
SULLIVAN, ALBERT J. (A)

*NORTH HAVEN*
*ALLEN, JOHN C. (A)
CASHMAN, JUSTIN (N)

*SEYMOUR*
CHOBIAN, J. A. (A)

*UNION CITY*
TYLEC, LEO L. (A)

*WALLINGFORD*
*BOYARSKY, HARRY M. (A)
*BRECK, CHARLES A. (A)
MURPHY, THOMAS B. (N)
*PELZ, KURT (A)
*WILSON, GEORGE C. (N)

*WATERBURY*
BACKUS, LOUIS C. (N)
*BERMAN, BERNARD A. (A)
*BIZZOZERO, ORPHEUS J. (A)
BONNER, ROBERT A., JR. (PH)
BOWEN, JOSEPH J. (A)
BURKE, JOSEPH (N)
COSHAK, MORRIS (A)
*DIONNE, ULRIC A. (A)
DUBOIS, ROBERT L. (N)
EGAN, JOHN J. (A)
*GOODRICH, WILLIAM A. (A)
*HARTY, JOHN E. (N)
*HERRMANN, ALBERT E. (A)
JENNES, MILTON L. (A)
*JENNES, SIDNEY W. (A)
LaBRECQUE, FREDERICK F. (N)
*LENKOWSKI, WILLIAM J. (A)
LEONARD, GEORGE A. (A)
LEWICKI, EDWARD (N)
*MARGOLIUS, NORMAN C. (A)
MAYO, ELLIOTT R. (N)
NELSON, ROGER B. (N)
PASETTO, EDO (A)
*POST, EDWARD A. (PH)
REICHENBACH, ALFRED (A)
REYNOLDS, JOSEPH A. (PH)
ROGAWSKI, ALEXANDER S. (A)
RUBY, ROBERT J. (A)
SALTZMAN, JACOB A. (A)
SAYERS, DANIEL O. (A)
*SKLAVER, JOSEPH (A)
STANESLOW, JOHN S. (N)

*WEST HAVEN*
*APPELL, HAROLD S. (N)
*CHASNOFF, JOHN A. (A)
EPSTEIN, CHARLES J. (PH)
KOSTER, LEO W. (PH)
O'CONNELL, WILLIAM M. (N)
SAPOSNIK, JACOB J. (A)

## NEW LONDON COUNTY

*GROTON*
*SZLEMKO, EMIL (A)

*JEWETT CITY*
ANSELL, HARVEY B. (PH)

*MYSTIC*
†LEON, A. JOSEPH (A)
*RYLEY, ROGER N. (N)

*NEW LONDON*
*BARON, SHIRLEY H. (N)
BECKER, JOSEPH (A)
COMSTOCK, EDWARD R. (A)
HARTMAN, FREDERICK B. (N)
HENKLE, ROBERT T. (PH)
IRWIN, HAROLD (N)
KRINSKY, CHARLES M. (A)
MORAN, JAMES P. (N)
MORRIS, JOYCE S. (A)
*RAPP, ALBERT C. (A)
†SAVAGE, PHILIP J. (A)
*WIES, CARL H. (A)
SCOVILLE, DOROTHEA H. (PH)
WOODWARD, JOSEPH C. (N)

*NORWICH*
DALY, JOSEPH L., JR. (A)
*FRIEDMAN, EMERICK (A)
*HERSEY, THOMAS F. (A)
KETTLE, RONALD H. (A)
*LUKOSKI, WALTER A. (A)
MOORE, MAURICE R. (A)
PEPE, ANTHONY J. (A)
RAYMER, JOHN G. (N)
TAYLOR, HOYT C. (N)
TISSENBAUM, MORRIS J. (A)

*STONINGTON*
HALIDAY, EARLE G. (A)

*TAFTVILLE*
*BERGENDAHL, HAROLD (A)

*UNCASVILLE*
LUBCHANSKY, JACOB H. (A)

## TOLLAND COUNTY

*MANSFIELD DEPOT*
LEONARD, ROBERT J. (N)

*ROCKVILLE*
BURKE, FRANCIS H. (A)
*SCHNEIDER, WILLIAM (A)

WINDHAM COUNTY

*DANIELSON*
GARCIN, CECIL R. (N)

*MOOSUP*
COUTURE, A. JOSEPH (A)

*NORTH GROSVENORDALE*
ROY, JOSEPH L. (A)

*PUTNAM*
BATES, DAVID H. (N)
LaPALME, JOSEPH A. (N)
MARGOLICK, MOSES (A)

*WILLIMANTIC*
*OTTENHEIMER, EDWARD J. (A)
ROCH, GEORGE E. (N)
†SHEA, RICHARD E. (A)
VERNON, SIDNEY (A)

## THESE GAVE

## CONTRIBUTORS TO THE BUILDING FUND, OCTOBER 6 TO NOVEMBER 10

Fairfield County

Newton, Louis, Bridgeport
Moore, Clifford D., Newtown
Vickers, J. Leonard, Greenwich
Banks, Daniel T., Bridgeport
Buckmiller, Frank C., Bridgeport
Gildea, Mark A., Bridgeport
Desmond, Waldo F., Newtown
Tracey, Edward J., Norwalk
Jones, Elwood K., Bridgeport
Sekerak, Arthur J., Bridgeport
Lynch, Robert J., Bridgeport
Horn, Martin I., Bridgeport
Keddy, Russell, Stamford
Oberg, Frank T., Bridgeport
Brooks, Paul L., Bridgeport
Foley, Francis X., Bridgeport

Hartford County

Young, William G., Hartford
Gallivan, John N., East Hartford
Woodward, Harold B., Bristol
Osborn, Stanley H., Hartford
Richardson, Ralph A., Bristol
Goddard, Harvey B., East Hartford
Seideman, Roy M., Hartford
Dunn, George W., New Britain
Nestos, Peter A., Bristol
Robbins, Benjamin B., Bristol
Mickle, F. Lee (associate), Hartford
Morse, L. Rogers, Hartford
Kunkel, F. Earle, Hartford
Little, Milton F., Hartford
Cogswell, Lawrence P., Hartford

Litchfield County

Wersebe, Frederic W., Washington

Middlesex County

Sherwood, Henry, Durham
Frank, Harry S., Middletown
Harvey, Carl C., Middletown

New Haven County

Curran, Harold J., Waterbury
Allen, Harry E., Waterbury
Petrucelli, Rocco J., Meriden
Hitchins, Clayton S., New Haven
Lowenstein, Bertrand, New Haven
Fiorito, Joseph A., New Haven
Phillips, Frank L., New Haven
Carpentieri, Anthony L., Waterbury
MacCready, Paul B., New Haven
O'Brien, William J. H., New Haven
Winternitz, Milton C., New Haven
Allen, Edward P., New Haven
Boisvert, Paul L., New Haven
Nahum, Louis H., New Haven
Poole, Allan K., New Haven
Pelliccia, Orlando, Jr., New Haven

New London County

Sturtevant, James M., New London

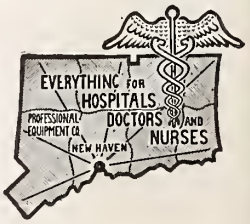
## War Medicine Bows Out — Enter Occupational Medicine

The American Medical Association announces that with this December issue *War Medicine* will be discontinued. In its place will be published a new journal, *Occupational Medicine*, not a specialty journal, but one intended to encompass the interests of the general practitioner and of the specialist and to reflect a broad and sweeping picture involving millions of persons.

## NOTICE

The Journal has been asked to establish exchanges with a Spanish publication, Revista De Sanidad E Higiene Publica, and with a Ukrainian medical publication. If any of our readers wish to receive either of these publications and contribute extracts of interesting material contained therein, communicate with: Managing Editor, Connecticut State Medical Journal 54 Church Street, Hartford 3, Conn.

**PROFESSIONAL HEADACHES:** — Few medical men can run an office without an occasional headache. No matter what type of equipment gets out of order in your office, call 7-2138 with complete confidence. We have a specially trained service to handle emergency calls or routine repair jobs. Turn your headaches over to us! The Professional Equipment Co.




(SEE PAGE 2)

# FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.
GRACE MOONEY, PH.D.
258 CHURCH STREET NEW HAVEN

## SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

**The 1945 semi-annual meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, at 3:00 P. M., Thursday, December 13.**

**The Council of New England State Medical Societies will be the guests of the House of Delegates.**

Joseph H. Howard, President
Creighton Barker, Secretary

### Agenda

1. Call to order, Arthur H. Jackson, First Vice-President.
2. Introduction of the President, Joseph H. Howard.
3. Introduction of guests.
4. Action on the budget of the Society and fixing dues for 1946.
5. Report of the Chairman of the Council including summary of the Annual Meeting of the House of Delegates of the American Medical Association, and progress report on prepaid medical service.
6. "The Council recommends to the House of Delegates that the Connecticut State Medical Society record with the President of the United States and Connecticut Representatives in the Congress of the United States that:

   "WHEREAS the United States Public Health Service has for more than 100 years been the Federal agency officially and competently concerned with the prevention of disease and of the improvement of the health of the people of the United States, and

   "WHEREAS the United States Public Health Service is under the direction of a Doctor of Medicine and is organized and staffed with technical personnel to administer national health projects skillfully, economically and with good judgment:

   "The Connecticut State Medical Society advocates the transfer of all health and medical functions of the Children's Bureau of the Department of Labor to the United States Public Health Service, in the interest of efficiency and to strengthen the wise usefulness of the Children's Bureau to the people of the United States."
7. Report and recommendations of the Committee on Public Health, Howard S. Colwell, chairman.
8. Report and recommendations of the Committee on Public Relations, C. Charles Burlingame, chairman.
9. Report and recommendations of the Special Committee on a State-wide Blood Bank, Ralph E. Kendall, chairman.

### Council Meeting

The November meeting of the Council was held at the Society's office on November 2 and was called to order at 4:00 P. M. by the chairman, Dr. Miller. Present: Drs. Miller, Mullins, Moore, Weed, Thoms, Weld, LaMoure, Campbell, Gildersleeve, Howard, Gibson, Speight, Barker. Absent: Drs. Murdock, Paine.

1946 DUES

The Treasurer reporting for the Budget Committee presented the Society's budget for 1946 and recommended that the dues for the coming year be continued at $20.

WAR HISTORY COMMITTEE

Further consideration was given to the Committee on History of Participation in World War II and the Committee was organized as follows: Chairman Ralph L. Gilman, Norton Canfield, Clair B. Crampton, James C. Fox, Ira V. Hiscock, Lewis F. Middlebrook, Ralph M. Tovell.

BUILDING FUND

A progress report from the Board of Trustees of the Building Fund was acepted and it was voted:

That the Board be commended and thanked for the gratifying results of its solicitation for funds and be asked to continue to seek contributions with the view of having as widespread a participation as possible among the members of the Society without regard to the original goal of $50,000 and to go to any larger amount which in the judgment of the Board is obtainable.

That the Board be asked to present a report to the Council at its meeting on March 1, 1946 setting forth the Board's proposals and recommendations for providing a home for the Society and that this report be submitted to the House of Delegates at its Annual Meeting in May 1946.

1946 ANNUAL MEETING

It was voted that the 1946 Annual Meeting be held in Hartford on Wednesday, Thursday and Friday, May 1, 2 and 3. The meeting of the House of Delegates will be held on May 1.

TUMOR COMMITTEE

Edward J. Ottenheimer, Willimantic, recently discharged from the Army was named a member of the Committee on Tumor Study.

ADVISORY COMMITTEE TO STATE HOSPITAL STUDY

Acting upon a request from the Governor of Connecticut, a list of names was submitted from which appointments might be made for the Advisory Committee to the State Health Department when it engages in the study of hospital and medical care in the state that will be authorized by the passage of S. 191, the Hill-Burton Bill by the Congress of the United States.

CHILDREN'S BUREAU OF THE DEPARTMENT OF LABOR

It was voted to present a resolution to the House of Delegates seeking the support of the Society in a request for the transfer of the Children's Bureau of the Department of Labor to the United States Public Health Service.

HARTFORD INDUSTRIAL HEALTH CLINIC

Consideration was given to a memorandum from the Society's Committee on Industrial Health concerning the establishment of a full time industrial health clinic in the City of Hartford and it was voted that:

The Council approves in principal the proposals for an Industrial Medical Clinic made in a memorandum received from the Committee on Industrial Health with the exact stipulations that:

1. Treatment given in the proposed clinics be available only to persons in the employ of industries participating in the clinic and for conditions incident to such employment only.

2. No treatment or service be rendered to the families or dependents of such employed persons.

3. A Medical Advisory Committee appointed by the Hartford County Medical Association be a permanent part of the organization to provide authoritative advice on matters relating to professional policy and physician-patient relationships.

AMERICAN MEDICAL ASSOCIATION SECTION ON GENERAL PRACTICE

It was voted to approve a resolution from the New London County Medical Association instructing the delegates to the American Medical Association to support a resolution to establish a Section on General Practice in the American Medical Association.

## Directors of Connecticut Hospital Service

The Council has nominated Arthur B. Landry, Hartford; William C. McGuire, New Haven and Ralph T. Ogden, Hartford, to represent the Society on the Board of Directors of Connecticut Hospital Service.

## Meetings Held During November

Thursday, November 1, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Friday, November 2, 4:00 P. M.
Council of the Society

Thursday, November 9, 4:00 P. M.
Executive Committee, New Haven District, Connecticut Cancer Society

Tuesday, November 13, 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board at Hartford

Wednesday, November 14: 10:00 A. M.
Written examinations of the Connecticut Medical Examining Board at Hartford

5:00 P. M.
Committee on Public Relations

Monday, November 19, 4:00 P. M.
Executive Committee, New Haven District, Connecticut Cancer Society

Tuesday, November 27, 10:00 A. M.
Oral interviews of the Connecticut Medical Examining Board at New Haven

Wednesday, November 28, 10:00 A. M.
Oral interviews of the Connecticut Medical Examining Board at New Haven

7:00 P. M.
Committee on Industrial Health
178 Jackman Ave., Bridgeport

## Meetings Scheduled for December

Tuesday, December 4, 3:00 P. M.
Committee on Public Health

Thursday, December 6, 4:00 P. M.
Executive Committee, Connecticut Cancer Society

Sunday, December 9, 12:30 P. M.
Committee on Public Relations, 248 North Whitney St., Hartford

Thursday, December 13, 1:00 P. M.
Council of the Society

3:00 P. M.
Semi-annual meeting of the House of Delegates, New Haven Medical Association, 364 Whitney Ave.

Unless otherwise specified, meetings are held at the offices of the Society, 258 Church Street, New Haven.

## Proposed Budget for 1946

| | | |
|---|---|---|
| Estimated Income from Dues | $30,000.00 | |
| Estimated Income from Journal | 19,000.00 | |
| Total Estimated Income | $49,000.00 | $49,000.00 |
| **BUDGET ALLOTMENTS** | | |
| Council | $ 250.00 | |
| Chairman Council | 300.00 | |
| Prepaid Medical Service | 250.00 | |
| Treasurer's Contingent Fund | 3,000.00 | |
| | $ 3,800.00 | $ 3,800.00 |
| Secretary's Office | | |
| Personal Services | $16,000.00 | |
| Rent | 1,500.00 | |
| Annuity | 1,000.00 | |
| Miscellaneous | 2,000.00 | |
| | $20,500.00 | $20,500.00 |
| Treasurer's Office | | |
| Auditors | $ 360.00 | |
| Treasurer's Agent (bank) | 200.00 | |
| Postage and Printing | 250.00 | |
| Personal Service | 750.00 | |
| | $ 1,560.00 | $ 1,560.00 |
| Journal | | |
| Personal Service | $ 6,750.00 | |
| Rent | 400.00 | |
| Miscellaneous | 1,500.00 | |
| Manufacturing Cost | 14,000.00 | |
| | $22,650.00 | $22,650.00 |
| | | $48,510.00 |

## The House of Delegates

The President of the Society
The President-elect of the Society
The Executive Secretary of the Society
The Treasurer of the Society
The Delegates to the American Medical Association
The Editor of the Journal

### Councillors

S. F. Mullins, *Fairfield*
A. B. Landry, *Hartford*
F. A. Weed, *Litchfield*
H. E. Speight, *Middlesex*
G. H. Gildersleeve, *New London*
C. T. LaMoure, *Tolland*
R. C. Paine, *Windham*
H. Thoms, *New Haven*

### Elected Delegates

#### Fairfield County

J. G. Booe, *Bridgeport*
J. D. Booth, *Danbury*
C. S. Conklin, *Bridgeport*
W. F. Desmond, *Newtown*
R. H. Edson, *Shelton*
J. D. Gold, *Bridgeport*
J. V. Halloran, *Cos Cob*
D. F. Keegan, *Bridgeport*
E. F. Meschter, *Stamford*
F. M. Meyer, *Bridgeport*
C. D. Moore, *Newtown*
H. C. Sherer, *South Norwalk*
C. H. Sprague, *Bridgeport*
O. L. Stringfield, *Stamford*

#### Hartford County

W. W. Bunnell, *Farmington*
R. S. Buol, *New Britain*
C. C. Burlingame, *Hartford*
J. E. Darrow, *New Britain*
E. A. Deming, *Hartford*
S. Donner, *Hartford*
B. B. Earle, *Glastonbury*
A. R. Felty, *Hartford*
W. R. Hanrahan, *Bristol*
L. P. Hastings, *Hartford*
G. G. Keefe, *Hartford*
G. A. F. Lundberg, *Manchester*
A. P. Pratt, *Windsor*
R. A. Richardson, *Bristol*
B. L. Salvin, *Hartford*
W. F. Storms, *Wethersfield*
E. J. Whalen, *Hartford*
B. N. Whipple, *Bristol*

#### Litchfield County

T. J. Danaher, *Torrington*
M. J. Reidy, *Winsted*
H. W. Markwald, *New Hartford*

#### Middlesex County

F. H. Couch, *Cromwell*
J. W. Fisher, *Middletown*
W. E. Wrang, *Middletown*

#### New Haven County

S. M. Atkins, Waterbury
C. H. Audet, *Waterbury*
C. F. Batelli, *New Haven*
H. S. Colwell, *New Haven*
A. N. Creadick, *New Haven*
W. J. H. Fischer, *Milford*
C. B. Gibson, *Meriden*
W. E. Hill, *Naugatuck*
R. J. Hinchey, *Waterbury*
A. J. Jackson, *Waterbury*
C. E. Johnson, *New Haven*
J. I. Linde, *New Haven*
R. E. McDonnell, *New Haven*
M. Heminway Merriman, *Waterbury*
R. W. Nichols, *New Haven*
J. H. Root, *Waterbury*
G. M. Smith, *New Haven*
H. M. Wilson, *New Haven*

#### New London County

C. G. Barnum, *Groton*
C. E. Bielecki, *Norwich*
W. H. Weidman, *Norwich*
T. Soltz, *New London*

#### Tolland County

W. L. Higgins, *South Coventry*

#### Windham County

R. L. Gilman, *Storrs*
B. Rafferty, *Willimantic*

## Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Albom, Jack J., West Haven (A)
Andrus, Oliver B., Devon (A)
Berlowe, Max L., New Haven (A)
Berman, Bernard A., Waterbury (A)
Buckhout, George A., Bridgeport (A)
Buckley, Willard E., Middletown (A)
Chester, Lewis L., New Britain (A)
Chipman, Sidney S., Norwalk (A)
Claiborn, Louie N., New Haven (A)
Carpentieri, Anthony L., Waterbury (A)
Castaldo, Louis F., Bridgeport (A)
Centrone, Patrick A., North Haven (A)
Cogland, John N., Hartford (A)
D'Ambruoso, Dominic C., Derby (A)
Davis, Jachin B., New Haven (A)
Diskan, A. Elmer, Manchester (A)
Eckert, George R., Danbury (A)
Gentile, Angelo L., New Haven (A)
Greenspun, David S., Bridgeport (A)
Hebard, George, New Canaan (A)
Herrmann, Albert E., Waterbury (A)
Margolius, Norman, Waterbury (A)
Miller, Harry B., New Britain (A)
Mott, Frederick E., New Haven (A)
Nevulis, Anthony V., New Britain (A)
Nodelman, Jacob, New Haven (N)
Ottenheimer, Edward J., Willimantic (A)
Patterson, Frederick A., Norwalk (A)
Pelz, Kurt, Wallingford (A)
Piccolo, Pasquale A., New Haven (A)
Pitock, Morris P., Fairfield (A)
Rubin, George A., New Haven (A)
Ryan, V. Gerard, Portland (USPH)
Scanlon, John J., South Norwalk (A)
Shenker, Benjamin M., Middletown (A)
Silver, Gershon, Hartford (A)
Simses, John P., Bridgeport (A)
Sklaver, Joseph, Waterbury (A)
Sullivan, Arthur B., West Hartford (A)
Thorne, Lewis, New Haven (A)
Tovell, Ralph M., Hartford (A)
Unsworth, Arthur C., Hartford (A)
Wallace, V. G. H., Norwalk (A)
Wies, Frederick A., New Haven (A)

## RETURNING MEDICAL OFFICERS

The Secretary's Office wishes to be notified promptly of your return to civilian life and your mailing address. Please keep us informed and give our Medical Officers Service Bureau an opportunity to help you.

## Dr. Fulton Elected President Army Medical Library Honorary Consultants

The second annual meeting of Honorary Consultants to the Army Medical Library was held recently in Cleveland, Ohio, for the purpose of electing officers to the association. Among those attending were: Major General George F. Lull, Deputy Surgeon General; Colonel Harold W. Jones, former director of the Army Medical Library, retired; and Colonel Leon L. Gardner, present director of the Army Medical Library.

The following officers were elected: President, Dr. John F. Fulton; Vice-President, Dr. Chauncey D. Leake; Secretary-Treasurer, Colonel Harold W. Jones. Major General Lull was elected on the Executive Committee. The action taken by Congress toward erecting a new building for the Library was one of the main topics of discussion.

## Drs. Creadick and Howard Appointed by Governor

A. Nowell Creadick, M.D., of New Haven and Joseph H. Howard, M.D., of Bridgeport, have been appointed by Governor Baldwin to the seven member "State Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm." Dr. Creadick, president of the Connecticut Cancer Society, was made chairman of the newly formed Connecticut commission. Stanley H. Osborn, health commissioner of Connecticut, is an ex-officio member. The commission was created by the 1945 General Assembly to make a preliminary survey of existing facilities in Connecticut for the care and treatment of chronically ill, aged and infirm persons in the State and to offer recommendations for the development of new, improved techniques for such care and treatment in post war years.

## Survey of Tumor Clinics

The Committee on Tumor Study of the State Medical Society has appointed N. William Wawro to conduct a study of the clinical aspects of Connecticut's Tumor Clinics. With the cooperation of the Association of Tumor Clinics, Dr. Wawro will make visits to clinics and will report to the Committee on Tumor Study his findings and recommendations before February 1. This is not a study of record keeping, which is considered the province of the Division of Cancer Research of the State Department of Health. Dr. Wawro's activities will fit into the general plan of the basic audit or survey sponsored by the Connecticut Cancer Society, in which the State Division of Cancer Research and the Committee on Tumor Study are cooperating.

## Cancer Problem Survey

President A. Nowell Creadick of the Connecticut Cancer Society reports that plans are being matured for a survey (or basic audit) of the whole cancer problem in Connecticut. This was initiated to guarantee that the funds of the Society should be wisely and effectively spent. The survey will be conducted under the direction of Alfred L. Burgdorf, chairman of the Medical Advisory Committee, and Prof. Ira V. Hiscock, vice-president, for the Society, with the cooperation of the Division of Cancer Research of the State Department of Health and the Committee on Tumor Study of the State Medical Society.

In the meantime, certain grants have been made for clinical research and personnel. These are announced below. With each notice of the allocation of funds was sent a letter urging closer cooperation between clinics and Field Army Committees in developing a community service which apparently is of most vital concern to the success of the whole program.

## Cancer Society Grants for Personnel and Research

Grants totalling $44,935 have been allocated to hospitals and communities in the state by the Connecticut Cancer Society as a part of the program made possible by its 1945 campaign. Of this sum, $16,000 will be used to finance research, including a basic audit of cancer facilities and needs in the state; $18,750 for specialized nursing, medical social work and health education personnel; $10,185 for a Field Army fund for local service to patients and activities in cooperation with the tumor clinics.

In August clinics and Field Army units were invited to submit requests for funds to cover needs in the cancer field. These were considered by the Medical Advisory Committee of the Society, a body of seven members named by the Committee on Tumor Study of the State Medical Society, with Dr. Alfred L. Burgdorf as chairman. Certain general policies were adopted for the present year. With the limited funds available it was the decision of the

committee not to recommend any grants for equipment. Money was allotted where it was considered that the greatest immediate opportunity for accomplishment existed. Requests for personnel to improve local cancer programs or to provide care for patients were approved. These varied with the locality and were encouraged as pilot programs to guide the Society in future years.

In response to applications for funds, the Medical Advisory Committee recommended the following grants for personnel on the basis of a one year period, and these were approved by the Finance and Executive Committees:

*Bridgeport Hospital*—For a Tumor Clinic Service worker and her expenses, to follow up cancer cases, $3,500.

*Greenwich District*—For part of the salary of a health educator, the balance to be paid by the Greenwich Tuberculosis and Health Association, $1,600.

*Hartford District*—For a medical social worker to act as executive secretary of the district program, $3,500.

*New Britain Hospital*—For a secretary-social worker of R.N. grade, $3,000.

*New Haven Hospital*—For a nurse "whose duties shall be the active care of the cancer patient undergoing treatment for the disease," salary and expenses, $3,500.

*New London County*—For a nurse to work with the Tumor Clinics of Backus Hospital, Norwich, and Lawrence and Memorial Associated Hospitals, New London, and to serve the people of the county, $3,000.

*Windham District*—For nursing care and follow up of cancer patients through the Visiting Nurse Association, $650.

Professor Ira V. Hiscock, vice-president of the Society, and Dr. Burgdorf were appointed to carry out plans for the basic audit, in cooperation with the Division of Cancer Research of the State Department of Health and the Committee on Tumor Study of the State Medical Society. The Division of Cancer Research is already preparing the statistical material of the survey. The Committee on Tumor Study has appointed Dr. N. William Wawro to conduct a study of the clinical aspects of Connecticut tumor clinics. With the aid of these studies the Connecticut Cancer Society plans to complete the audit as the basis for a long term cancer program.

Funds have been made available to the Hartford district for two clinical research projects proposed by Dr. Ralph E. Kendall, to be carried out with the aid of the Hartford Field Army. Grants have also been allotted to New Britain Hospital for research under the direction of Dr. Paul D. Rosahn, and for an investigation proposed by Dr. Clyde L. Deming, of Yale University School of Medicine.

Nationally, the "whole basic problem of the formation and development of living tissue, essential to the understanding of cancer," is included in the research plans of the American Cancer Society, as announced by its advisory body, the Committee on Growth of the National Research Council. The sum of $500,000 will be used for research as follows: chemistry, $150,000; physics, $100,000; biology, $150,000; clinical research, $100,000. Of this, $50,000 will go for fellowships to attract to cancer research able men released from the armed forces and war time research.

## The Linacre Quarterly

Under the new editorship of the eminent and esteemed Father Schwitalla, *The Linacre Quarterly* appears in a new form. To quote from the January-April 1945 issue: "Its title [is] enclosed by a horizontal border of liturgical symbolism suggestive of nature (the plant) and science (the book) transfused by faith (the cross of the bookmark). The title in Old English is well reminiscent of the days of Linacre himself, who in the year 1518 under the sponsorship and patronage of none other than Henry VIII, founded the Royal Academy of Physicians in London. Then with the declaration on the title page that this is the official organ of the Federation of Catholic Physicians' Guilds, a new note is introduced with the few words "A Journal of the Philosophy and Ethics of Medicine.'

## Infantile Paralysis Group Meets

Highlights of the progress of the fight against poliomyelitis, locally, throughout the state, and nationwide, were reported upon at a public meeting held at the New Haven Medical Association Building, 364 Whitney Avenue, New Haven, on the evening of Thursday, November 8. The meeting, sponsored by the New Haven County Chapter of the National Foundation for Infantile Paralysis, Inc., was open to the public. A dinner, attended by some forty or more members of the Chapter, and their guests, preceded this meeting. Mr. Matthew Birmingham, secretary of the New Haven County Chapter, extended a welcome to the group, and Dr. Ira

V. Hiscock, professor of public health at Yale University, and county chairman, presided.

Dr. Joseph I. Linde, health officer of New Haven, and chairman of the Executive Committee of the Chapter, opened the discussion with a report of New Haven County Chapter activities. He reviewed the work of the Chapter from 1941 to the present. Funds were used for lectures to public health nurses, demonstrations in treatment methods, care of patients in hospitals and convalescent hospitals, the sending of physicians and other personnel for training in methods of treatment, operation of the Curative Workshop, and maintenance of investigation and field work. The program proved its worth in the 1943 outbreak when, with approximately 200 cases in New Haven and nearby towns, the Chapter met successfully its first real test. Dr. Linde indicated as the three objectives of the program: (1) furnishing of financial assistance to all those in need of it; (2) providing professional education; (3) advances in general public health education.

Dr. Charles McPartland, health officer of West Hartford and state chairman of the National Foundation, emphasized the need for uniformity among the chapters throughout the state in their procedure and services, and also called for more publicity in the home communities as to services being rendered infantile paralysis victims.

Dr. Louis Spekter spoke for the State Health Department and told how that department assists and augments the work the Infantile Paralysis Foundation by establishing and coordinating diagnosis and treatment centers, and in dispatching trained physiotherapists wherever needed. Complete plans have been organized for any emergency which may arise.

Dr. George Fox of Meriden, brought the greetings of the State Medical Society and lauded the fine relationship existing between the Foundation and the medical profession. He promised that so long as the Foundation persists in its attack upon poliomyelitis it will have the support "all the way" of the State Medical Society.

Miss Elaine Whitelaw, director of the Women's Division of the National Foundation, reported on the work being done by that group, now in its second year of existence. This Division has worked in cooperation with a score or more of leading national women's organizations in providing service and education through training and fund raising. The women have shown themselves to be a tremendous factor in the success of the Foundation, she said.

Dr. Don Gudakunst, medical director of the National Foundation, who had just returned from a trancontinental trip which took him into hundreds of communities to consult with chapter leaders, reported on highlights from the National Foundation and the field.

Dr. Gudakunst remarked that the vast expenditures of the National Foundation in the fight against a comparatively uncommon disease are sometimes questioned. However, he pointed out, National Foundation funds are also used to combat other serious diseases challenging the nation's health.

Although the peak of the structure reared by the Foundation, through the gifts of millions of men, women and children all over the nation, points directly toward the conquering of infantile paralysis, the base upon which this structure stands is as broad as the whole field of medicine. The grants given for the study of the virus diseases are not confined to poliomyelitis alone. While the medical profession is well armored against bacterial infections, the pneumonias, typhoid, diphtheria, and many other infections, there is much to be done with the virus diseases. Studies made possible by Foundation grants will eventually solve all or many of the virus disease problems, even those in plant life, having a tremendous effect on agriculture.

Grants by the Foundation, though aimed directly at infantile paralysis, are proving of value in the fight against cancer, the blood diseases, and diseases of the central nervous system as well as others. The training of nurses, and physiotherapists, and the equipment of hospitals and the providing of hospital beds is not alone for benefit of infantile paralysis but for sufferers from all manner of disease who will share in these benefits. Fellowships provided in orthopedic surgery enlarge the general knowledge and facilities for the treatment and healing of bone conditions. Grants for health education will make available trained educators for official and unofficial health agencies, who will teach the general public how to use the facilities offered, or in brief—How, When and Where to Get Medical Care. All these grants and services are aimed directly at the elimination of infantile paralysis, but are wide enough to share in the fight against all illness and suffering.

## Public Relations Conference of A. M. A.

Specific recommendations for definite action resulted from the first A. M. A. Public Relations Conference held under the direction of the Council on Medical Service and Public Relations in Chicago October 19-20.

Developed along new lines, it was a sort of "grass roots" affair with 115 representatives registered from thirty-five states and the District of Columbia. A high point of the Conference was the talk by Major General Paul R. Hawley, medical director of the Veterans' Administration. Informal, frank, pointed, tied together with keen bits of midland humor, it left a fine impression. He has a tremendous job, but no one who heard him had any doubt as to his ability to tackle such a tough problem.

Following a quick getaway briefing by E. J. McCormick, M.D., chairman, on the first day, the Conference was streamlined to produce definite results into seven informal round table discussion groups under seven moderators. On the second day each moderator prepared a round-up report on each round table embodying definite recommendations to be worked up by the Council for presentation for action by the Board of Trustees and the House of Delegates of the A. M. A. Definite recommendations were made in regard to:

1. Prepayment plans.
2. EMIC program.
3. Fourteen point program.
4. Placement of returning medical officers.
5. Publicity and public relations.
6. Veterans' Administration.
7. Rural health.

### PREVIEW OF CONFERENCE RECOMMENDATIONS

*On the A. M. A. Fourteen Point Program*

With reference to Point No. 1 relative to better living conditions, "We recommend constant publicity on the facts of this particular problem through the A. M. A., the state associations, the county societies, and the women's auxiliaries, by addresses and articles not only in the medical journals but also in the lay press."

For Point No. 2 concerning preventive medicine, "The implementing of this second point is by means of legislation. Such legislation should also be of interest to the A.P.H.A., the State and Territorial Health Officers Association, and the U.S.P.H.S. We recommend that the A. M. A. sponsor a conference with these groups in an endeavor to enlist their cooperation in legislative efforts to accomplish the purpose of this item."

And on Point 14 referring to Veterans' Administration and U. S. Public Health Service, "Free choice of physician for all veterans under the care of the Veterans' Administration and integration into the voluntary plans of hospitalization and medical care."

*On the EMIC program*

"That the present Medical Advisory Committee to the Children's Bureau is not truly representative of the entire medical profession. Any program of that Bureau must be administered through the States' Medical Associations, and they should be represented."

"That the present advisory steering committee to the Children's Bureau be abolished and a new committee be established which shall consist of one representative from each state medical association . . . and such other medical organizations as have a direct interest in the functioning of the Bureau."

"That since the Children's Bureau is not properly related to the Department of Labor, it should be transferred to the Federal Security Agency until such time as all health and medical activities of the Government are segregated into a single department."

*On the Placement of Medical Officers*

"That all discharged medical officers be given terminal leave pay at the termination of their active duty and prior to the expiration of such accrued leave as they may have, thus enabling them to participate immediately in the benefits provided by Public Law 346 (78th Congress, G. I. Bill of Rights). Such a procedure will enable the returned medical officer to commence immediately his training in hospitals or medical schools after leaving the armed services."

"It is recommended that the Council on Medical Education and Hospitals be urged to set up at once a method for the more prompt approval of hospitals for residencies and consider the advisability of giving some temporary approval until formal inspections can be made."

### COUNCIL ACTION

The Council has approved the appointment of an Advisory Committee to direct the work on Prepay-

ment Medical Care Plans. The Committee will be composed of various plan directors and others interested in this problem. It will have the duty of setting up a program for gathering regular monthly or quarterly data on the plans; for analyzing such data, and reporting back to the plans or to medical societies interested in starting plans. An organization meeting will be held at the A. M. A. headquarters at the earliest possible date.

HEALTH COUNCIL IDEA GROWS

The Community Health Council idea as a medium for public relations and to assist in activating health programs seems to have a promising future. Until recently Health Councils have generally been local medical society projects. Dr. John Fitzgibbon has emphasized the importance of such Councils in the statement: "Most public health problems could be satisfactorily solved at the local level if local medical societies would assume the leadership in a plan of cooperative effort with other interested local organizations and agencies with whose leaders friendly relations were easily made or already existent."

Another program just instituted, and which presents a different and interesting approach to the problem, is that of the Michigan Health Council. This is not an effort solely by the physicians of Michigan but represents the combination and coordination of their influence and support with that of other organizations of the state which have a common interest. The Council was incorporated a year ago as a joint organization of the Michigan State Medical Society, the Michigan Hospital Association, Michigan Medical Service and Michigan Hospital Service.

## Another Connecticut First

One of the most significant actions of the Connecticut General Assembly of 1945 was the passage of new legislation for the study, care and treatment of inebriates. By the adoption of this measure, Connecticut became the first state to give public recognition to alcoholism as an extensive and serious health and social problem and to undertake the development of a program for the eventual control of the disease.

Public Act No. 406, in the revised form in which it was enacted, represented acceptance of a comparatively new philosophy of approach to handling the problem of alcoholism, since it provides for the establishment of a state board which is authorized to study the problem, publicize its findings, set up diagnostic and treatment facilities and conduct outpatient clinics. The dominance of this viewpoint in the formulation of the law, as opposed to the older concepts which advocated either punitive measures only, through prison sentences or large hospitals for all inebriates regardless of the underlying cause of the illness or of the possibility for rehabilitation, is an advance of far-reaching social implications.

The composition of the Board appointed by the Governor to direct this momentous and demanding task is a source of further satisfaction, for each choice appears to be thoughtful and wise. The members are Selden D. Bacon, PH.D., assistant professor of sociology at Yale University, Mrs. Edna A. F. Edgerton, Stamford, representative in the General Assembly, Arthur H. Jackson, M.D., Washington, Thomas P. Murdock, M.D., Meriden, and Abraham Ullman, State's Attorney at New Haven. The Board has held its first meeting and has selected for its chairman, Dr. Bacon who has been intimately associated with the field through his work in the Yale School of Alcohol Studies. Dr. Murdock has been designated vice-chairman and Mrs. Edgerton secretary of the Board.

An allotment of 9 per cent of the annual income from liquor license fees has been provided for the financing of the program and it is estimated that this will yield approximately $100,000. Undoubtedly the mature and able members of the Board will approach the development of a constructive state plan for the control of alcoholism with scientific care and deliberation. They have the sincere good wishes and the support of the medical profession in their undertaking.

## National Hospital Plan Proposed by U. S. Public Health Service

Under the title "Health Service Areas—Requirements for General Hospitals and Health Centers," the U. S. Public Health Service has published in Bulletin No. 292 "a plan for an integrated scheme of hospitals and related facilities to cover every section of the nation." This plan comes as a result of the recent discussion of further development and of unification of voluntary hospitals throughout broad areas with State and perhaps national financial assistance.

To quote from the foreword: "Certain concepts of service that are fairly well accepted by students of the subject and by practical hospital administra-

tors are fitted into the existing structure of voluntary and public hospitals. Supplements to these institutions are suggested where necessary to bring needed facilities within the reach of persons regardless of geographical location. The health center is expanded in function to serve as a device for relating and amplifying the work of hospitals and community health agencies. Since it is presumed that a large element of public financial support will be necessary, existing political units having powers of taxation are brought into association through the formation of service areas and regions. While financial considerations are omitted from the discussion, in the background is the familiar pattern of grants-in-aid for equalizing resources among communities and States."

The plan is admittedly a "library product," not an expression of policy of the U. S. Public Health Service nor a forecast of the future. The monograph is embellished with maps and tables in which are arranged a series of district and regional hospital centers with their hospital facilities, the estimated number of new general hospital beds needed for suggested hospital service districts, States, and the United States, and the estimated number of health centers per State. Under the plan Connecticut would have a primary hospital center in the Hartford district, with secondary centers in the New Haven and New London districts. An estimated 609 new general hospital beds would be needed, 490 in the Hartford district and 119 in the New London district, and an estimated 104 health centers would be needed throughout the State.

## News from Washington

### HILL-BURTON HOSPITAL BILL S. 191 REWRITTEN

The subcommittee of the Senate Committee on Labor and Education has rewritten S. 191 and reported it out to the Full Committee. On October 27 the Full Committee *reported it to the floor of the Senate*. Among the important features of the bill are:

1. Instead of appropriating $100,000,000 for construction for the fiscal year ending June 30, 1946, the new bill provides $75,000,000 each year for the first five years beginning the ficsal year of 1947.

2. The formula for allotment to states has been changed so that allotments will range from 33⅓ per cent to the most wealthy states to 75 per cent for the poorest.

3. The Surgeon General is instructed to prepare within six months, with the approval of the Federal Advisory Council and the Administrator, general regulations with regard to the

a. Number of general hospital beds that may be constructed in any specific area.

b. Specialized hospital beds.

c. Number and distribution of public health centers.

d. General manner of determining priority of projects.

e. General standards of construction and equipment.

f. Prevention of discrimination on account of race, creed or color.

4. Ten specific instructions are outlined for preparation of plans by the States. Briefly stated they are:

a. Designate a single agency to administer or supervise administration of the plan.

b. Show that this agency will have authority to carry out the plan.

c. Provide for an advisory council to consult with the agency.

d. Set forth a hospital construction program to be based on a survey of needs.

e. Set forth the relative need for projects and provide for their construction.

f. Provide methods of administering the plan.

g. Provide minimum standards for maintenance and operation of hospitals which receive Federal aid under this title.

h. Provide for an opportunity for a hearing before the agency to every applicant for a construction project.

i. Provide that the agency make such reports from time to time as the Surgeon General may require and give him, upon demand, access to the records upon which such information is based.

j. Provide that the agency will from time to time review its hospital construction program and submit to the Surgeon General modifications it deems necessary.

5. The definition of public health center is modified by limiting it to the provision of "public health services." The original bill had provided "medical care" as well.

## Ten Years of Service for Children

Under this title, with the additional words "under the Social Security Program," the Children's Bureau of the U. S. Department of Labor has published a survey of its accomplishments from August 1935 to August 1945. There are three reports dealing with Maternal and Child Health, Services for Crippled Children, and Child Welfare Services. Much of the credit for improvement in these fields, especially in the maternal and infant mortality figures, is attributed to the Social Security program. The validity of such deductions may be questioned by many. There is no doubt that the EMIC program has been a boon to many of the poorer states and might well be continued where the need for it remains. The Children's Bureau levels its accusing finger at the medical profession with the words that "it is estimated that still another 50 per cent of the deaths of mothers in childbirth might be prevented if all mothers had the care this country knows how to give." It then calls for 48,000 additional public health nurses and for an additional appropriation of $50,000,000 for an extension of the EMIC program "without discrimination because of race, color, national origin or residence."

The accomplishments of the Crippled Children program are less striking. "Fewer than 10 per cent of the Nation's physically handicapped children are receiving care through services developed under the Social Security program." A $25,000,000 additional appropriation is called for to be divided as follows: $5,000,000 for orthopedic cases, $5,000,000 "for children with other physically handicapping conditions," and $15,000,000 for rheumatic fever and heart disease cases. The joker in this program not brought out in the report is the almost unlimited extent of Government medicine involved where the upper limit of the *child* is 21 years and the definition of "crippled" is of the best quality of elastic.

Child Welfare Services were included in Social Security because in 1935 only about half the States had such divisions in their public welfare departments. There were found to be 7,400,000 boys and girls under 16 years of age on the relief lists, according to the Children's Bureau, and some 300,000 children dependent and neglected. Each year 200,000 children, more or less, have been brought into court for delinquency and thousands thrown into jail. The National Commission on Children in Wartime proposes an expansion of child welfare services under the Social Security program, over a 10 year period, "that would make coverage State-wide, so that individual guidance and service would be available to every child in special need." The funds from Washington would be allotted to States on a basis of need and not on a basis of ability to match dollar for dollar. These services likewise would be available without regard to color, race, creed, heredity or residence.

The striking fact evident to the careful reader of these reports is the intermingling of medical care and social reform being carried on simultaneously by the Children's Bureau. Granted there is plenty of need for both, it still is very apparent that Federal Medicine is not under the control of a Department of Health but is a function of certain socially minded members of the Department of Labor who have not succeeded in elevating it from the field where it remains a political football. The practice of medicine can hardly attain its desired results if geared up with a program for reducing juvenile delinquency. Social Security has much to accomplish before it will be prepared to embark upon functions which belong in the field of preventive and curative medicine.

## Penicillin Financed by U. S. A.

Although Dr. Florey of Oxford, England, was working in a country which has a well established program of socialized medicine, it was necessary for him to apply for a grant from the Rockefeller Fund in the good old U. S. A. to provide equipment for his laboratory. For the small sum of 1,280 United States dollars the clinical use of penicillin was pioneered. "We'll admit it was worth it even though England will get the credit," writes the editor of *Detroit Medical News*.

BOOKS — BOOKS — BOOKS — The next time you have a few minutes to spare, why not stop in and look over our miniature library. Current editions of medical, x-ray, and physical therapy publications on hand for your inspection. Professional Equpment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# *Doctor---*

## INFORM YOUR PATIENTS !

Hospitals and health centers are the vital tools of the physician, and we are in favor of the Hospital Construction Bill, which promises adequate health facilities in all parts of the country.

Before Congress as S-191, the Hill-Burton Bill, calls for a nation-wide study by state appointed commissions to determine the adequacy of health services in the several states. On the basis of these state controlled studies, federal funds for hospital construction will be granted upon request of local authorities where the need is demonstrated. Some minor aspects of this bill will be bettered by change, but in the main, it has been endorsed by the American Medical Association, the American Hospital Association, and apparently has excellent chances of adoption.

This country has developed a public conscience which will not tolerate the lack of essential health facilities, and we are convinced that medical and hospital care can be satisfactorily furnished only when the administration is close to and responsive to the people who are served.

WE DOCTORS FAVOR THE HILL-BURTON BILL BECAUSE IT DEVELOPS HEALTH FACILITIES WHERE THEY ARE NEEDED, AND PROVIDES FOR DECENTRALIZED ADMINISTRATION.

**The best public relations man that medicine ever had was the horse-and-buggy family doctor. As the family counsellor, consoler and friend, he established the finest possible public relations.**

**You are his successor in modern medicine. Your State Officers and Committee Members can only be helpers to you. In your daily contacts with your patients, tell them what organized medicine wants and why.**

# MEDICINE AND THE WAR

## Federal Security Agency Procurement and Assignment Service Washington 25, D. C.

Under date of October 18, 1945, all District Offices of Naval Officer Procurement were advised by the Bureau of Personnel as follows:

ONOP's may accept and process for appointment in USNR the application of any medical doctor between the ages of 21 and 50 and who is a graduate of an approved medical school. Should have visual acuity of at least 12/20 uncorrected, correctable to 20/20 and be otherwise physically qualified. Waivers may be granted in exceptional cases. Applicants must have Procurement and Assignment clearance. No positive procurement campaign desired. But suggest ONOP's advise Local Selective Service Boards of this change in policy.

## Baruch Committee Appoints Physical Rehabilitation Consultant

Dr. Frank H. Krusen, director of the Baruch Committee on Physical Medicine, has announced the appointment of Colonel Howard A. Rusk, MC—AUS, as consultant on physical rehabilitation for the Baruch Committee. Colonel Rusk, whose pioneering work as chief of the Convalescent Division of the Air Surgeon has attracted national attention, will make his headquarters at the New York office of the Committee created a year ago by Bernard M. Baruch. Dr. Krusen explained that the Committee plans to set up a blueprint for the guidance of communities in the establishment of community rehabilitation centers or services.

Colonel Rusk, before the war, practiced internal medicine in St. Louis and also was instructor in medicine at Washington University School of Medicine there. In December 1942 he established for the Army Air Forces at Jefferson Barracks the first rehabilitation program in the armed forces. In 1943 he was given the Lord and Taylor American Design Award for an outstanding contribution in the field of rehabilitation. For the past several months he has been chairman of the subcommittee on Civilian Rehabilitation Centers of the Baruch Committee.

## Army Medical Department Gets Six Per Cent of World War II Decorations

Of the 1,4000,409 decorations given in World War II in recognition of meritorious service and gallantry, six per cent were received by Medical Department personnel, according to a biennial report by General George C. Marshall. These figures are exclusive of the Air Medal and the Purple Heart.

## Work of Medical Department in World War II

In his Biennial Report to The Secretary of War, General George C. Marshall, Chief of Staff of the United States Army, paid tribute to the Medical Department for its outstanding work in World War II, as follows:

"The remarkable reduction in the percentage of the deaths from battle wounds is one of the most direct and startling evidences of the great work of the Army medical service. In the last two years Army hospitals treated 9,000,000 patients; another 2,000,000 were treated in quarters and more than 80,000,000 cases passed through the dispensaries and received outpatient treatment. This tremendous task was accomplished by 45,000 Army doctors assisted by a like number of nurses and by more than one half million enlisted men, including battalion-aid men, whose courage and devotion to duty under fire has been as great as that of the fighting men they assisted.

"One of the great achievements of the Medical Department was the development of penicillin therapy which has already saved the lives of thousands. Two years ago penicillin, because of an extraordinarily complicated manufacturing process, was so scarce the small amounts available were priceless. Since then mass production techniques have been developed and the Army is now using 2,000,000 ampules a month.

"Despite the fact that United States troops lived and fought in some of the most disease infested areas of the world, the death rate from non battle causes in the Army in the last two years was approximately that of the corresponding age group in civil life—

about 3 per 1,000 per year. The greater exposure of troops was counterbalanced by the general immunization from such diseases as typhoid, typhus, cholera, tetanus, small pox, and yellow fever, and, obviously, by the fact that men in the Army were selected for their physical fitness.

"The comparison of the non battle death rate in this and other wars is impressive. During the Mexican War, 10 per cent of officers and enlisted men died each year of disease; the rate was reduced to 7.2 per cent of Union troops in the Civil War; to 1.6 per cent in the Spanish War and the Philippine Insurrection; to 1.3 per cent in World War I; and to 0.6 per cent of the troops in this war.

"Insect borne diseases had a great influence on the course of operations throughout military history. Our campaigns on the remote Pacific Islands would have been far more difficult than they were except for the most rigid sanitary discipline and the development of highly effective insecticides and repellents. The most powerful weapon against disease bearing lice, mosquitoes, flies, fleas and other insects was a new chemical compound commonly known as DDT. In December 1943 and early 1944, a serious typhus epidemic developed in Npales. The incidence had reached 50 cases a day. DDT dusting stations were set up and by March more than a million and a quarter persons had been processed through them. These measures and an extensive vaccination program brought the epidemic under control within a month. Shortly after the invasion of Saipan an epidemic of dengue fever developed among the troops. After extensive aerial spraying of DDT in mosquito breeding areas, the number of new cases a day fell more than 80 per cent in two weeks. The danger of scrub typhus in the Pacific Islands and in Burma and China was reduced measurably by the impregnation of clothing with dimethyl phthalate.

"The treatment of battle neurosis progressed steadily so that between 40 and 60 per cent of men who broke down in battle returned to combat and another 20 to 30 per cent returned to limited duties. In the early stages of the war less than 10 per cent of these men were reclaimed for any duty.

"The development of methods of handling whole blood on the battlefield was a great contribution to battle surgery. Though very useful, plasma is not nearly as effective in combating shock and preparing wounded for surgery as whole blood. Blood banks were established in every theatre and additional quantities were shipped by air from the United States, as a result of the contribution of thousands of patriotic Americans. An expendable refrigerator was developed to preserve blood in the advanced surgical stations for a period of usefulness of 21 days.

"So that no casualty is discharged from the Army until he has received full benefit of the finest hospital care this Nation can provide, the medical service has established a reconditioning program. Its purpose is to restore to fullest possible physical and mental health any soldier who has been wounded or fallen ill in the service of his country.

"To insure that men are properly prepared for return to civilian life the Army established 25 special convalescent centers. At these centers men receive not only highly specialized medical treatment, but have full opportunity to select any vocational training or recreational activity, or both, they may desire. Men, for example, who have been disabled by loss of arms or legs are fitted with artificial limbs and taught to use them skillfully in their former civilian occupation or any new one they may select. Extreme care is taken to insure that men suffering from mental and nervous disorders resulting from combat are not returned to civil life until they have been given every possible treatment and regained their psychological balance."

### ARMY PERSONNEL RECEIVE INFLUENZA INOCULATIONS

All Army personnel have been ordered inoculated during the months of October and November with a new influenza vaccine as a preventive measure against influenza epidemics, the Office of The Surgeon General has announced.

The vaccine, made by injecting influenza virus into chick embryo, is to be administered in a single injection. Experimentation with the new vaccine was started early in 1943, but sufficient quantities for mass inoculation were not made available until the present year.

## Colonel Frederic H. Thorne, C.O. at Avon, Retires from Service

Colonel Frederic H. Thorne, MC, Commanding Officer of Old Farms Convalescent Hospital, Avon, Connecticut, is retiring from the Army after twenty-nine years of service with the Army Medical Department.

The greater part of his military career having been spent in the field of ophthalmology, Colonel Thorne was appointed head of the Army's rehabilitation center for the blind at Avon, Connecticut, in 1944, and has helped develop and extend the blind

training program there, pioneering in new training techniques.

A member of the Army Medical Department since 1917, Colonel Thorne served as a surgeon with the Sixth Division in France in World War I.

## War Medicine: Vol. 8, No. 2, August 1945

This issue of *War Medicine* contains two articles of considerable interest. The first entitled "Mechanics of Blast Injuries" is a report from the Department of Anatomy of Howard University College of Medicine by M. Wharton Young, M.D., PH.D. Early in World War II the subject of blast injury was reported on by Zimmerman and by several British writers. Recently John F. Fulton of Yale University School of Medicine published a review of the literature on this subject. The present report focusses attention on the effect of the pressure from blasts upon the cranium due to increased venous pressure, and the prevention of the same by preliminary ligation of the jugular veins. The writer calls attention to the manner in which the depth charge has changed the entire technic of antisubmarine warfare and warns of the possible similar future for the concussion bomb.

The other article of particular interest is Harvey, Butler, McMillen and Puckett's illustrated paper on "Mechanism of Wounding." Various phenomena connected with the production of a wound are observed and the sequence of events is visualized by high speed moving pictures showing the movement of the missile in water and gelatin gel. Roentgenograms demonstrate similar changes in living tissues.

Major Marvin F. Greiber, MC—AUS, discusses 'Narcosynthesis in the Treatment of the Noncombatant Psychiatric Casualty Overseas" and presents a few case histories illustrating the same. Lieutenant Colonels Hall and Hick, MC—AUS, submit their observations and impressions made in connection with the examination of civilian applicants for commissions and of reserve officers under consideration for active duty. Lieutenant Bernard Heinemann, SC—AUS, submits a bacteriological analysis of the incidence of Shigellas and Salmonellas isolated from American military personnel in Egypt. A total of 3,078 stools from patients with illnesses clinically suggestive of dysentery, diarrhea or gastroenteritis were cultured.

The usual twenty-five pages of current literature abstracts and eleven book reviews, more than usual, complete this issue.

## Promotions — Changes of Station

Capt. Leo Hymovich (Stamford) has been promoted to Major and is chief of Surgical Service at the Station Hospital, Ft. Moultrie, South Carolina, having been transferred from Stark General Hospital at Charleston.

Lieutenant Commander Reinhold F. Hertzberg, USNR (Stamford) has just informed us of his promotion to Commander and his appointment to chief of Surgical Service of a Naval Base Hospital in the Marianas.

Word has just been received of the promotion of Commander H. Bruno Arnold, USNR (New Haven) to Captain. He continues on duty in the Bureau of Medicine and Surgery at Washington.

Lieutenant Roger B. Nelson, USNR (Waterbury) was promoted to Lieutenant Commander on October 3, station unchanged.

# THE DOCTOR'S OFFICE

Edward H. Crosby, M.D., formerly Commander MC—USNR, announces the reopening of his office at 50 Farmington Avenue, Hartford, for the practice of bone and joint surgery.

Lawrence P. Cogswell, M.D., announces the reopening of his office at 179 Allyn Street, Hartford, for the practice of internal medicine.

Arthur C. Unsworth, M.D., announces the reopening of his office for the practice of ophthalmology at 179 Allyn Street, Hartford.

MAKING A MOUNTAIN OUT OF A MOLE —
is easy for a dermatologist using a Magni-Focuser. This new eye loop enables all medical specialists to magnify objects with the binocular clarity of normal vision. The Magni-Focuser is light, easy to wear, fits comfortably over eye glasses, leaves both hands free, relieves eye strain, and provides maximum efficiency in minimum time. Many uses in all branches of medicine will readily occur to you. One hint: try reading an x-ray film with a Magni-Focuser! Ask Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# MEDICINE AND THE VETERAN

MEDICAL ADVISORY COMMITTEE TO CONNECTICUT REGION OF U. S. VETERANS ADMINISTRATION

Joseph H. Howard, *Chairman*, Bridgeport
C. Charles Burlingame, Hartford
Arthur B. Landry, Hartford
Burr H. Curtis, Hartford
Cole B. Gibson, Meriden

## MEDICAL CARE OF VETERANS

Joseph H. Howard, M.D., *Bridgeport*

The confusion that exists regarding proper medical care of the veteran is shown in the variety of Bills introduced to Congress. They include reorganization of the existing Veterans Facilities; the establishment of a Bureau of Medicine and Surgery in the Veterans Administration; a commissioned service consisting of physicians and surgeons, dietitians, nurses, and medical technicians; a National Veterans Hospital Board to advise the Administrator of Veterans Affairs; A Bill to authorize the furnishing of medical and hospital treatment of certain veterans in private facilities; another to authorize treatment in hospitals nearest the place of residence; and lastly a Bill to authorize the appointment of an Advisory Committee of prominent members of the medical and related professions to advise the President with respect to the formulation of programs to provide medical care and hospitalization for veterans.

This last Bill, upon which no action has been taken, was introduced by Senator White of Maine for Senator Shipstead of Minnesota, and would seem to be the most logical method of attack of this huge problem. Since this is essentially a medical question, the plan should be drawn by the medical profession and presented to the President as a program suggested by physicians. Unless we take the leadership in this most perplexing problem, some means will be found to carry out the necessary examinations and treatment which the profession shall consider untenable, and the treatment of the veteran of inferior quality.

The Connecticut State Medical Society has for some time seen the advantage of an Advisory Committee to the Veterans Administration, and the Council has appointed such a committee to consult with the director of the Facility at Newington. It is the opinion of this Advisory Committee that we should bring pressure to bear on having veterans treated in their own community hospitals. With standardization of hospitals at the present high level, good care can be assured. The large newer Facilities to be built, as suggested by General Hawley, can be used for the more complicated cases requiring the care of trained specialists not ordinarily found in many cities. These would be exceptional cases.

Although many will be hospitalized for varying periods of time, the great bulk of veterans will be treated at out-patient clinics. With the establishment of proper out-patient clinics, many of those confined to Veterans Facilities can be discharged earlier to their own community for further treatment, thereby releasing beds in the Veterans Hospitals for more acute cases. The Advisory Committee, therefore, approves of the establishment of out-patient clinics in local hospitals, following the pattern of Bridgeport. This should not be known as the Bridgeport Plan, or the Connecticut Plan, but should be designated as the Doctors Plan for the Care of the Veteran.

The details of the means of establishing these out-patient clinics has been described in the Journal and also at the various County meetings. It is hoped that many hospitals throughout the State will put into effect the same procedure as soon as possible, and they may call upon the Advisory Committee for suggestions.

A few changes have been made regarding fees as announced by General Hawley in Chicago at the meeting of the Presidents and Secretaries of the forty-eight states on October 19 and 20. One of the criticisms had been that very few had seen the schedule of fees, and among those that had the opportunity to study these fees, there were differences of opinion regarding the fairness of some of them. Because of these criticisms, General Hawley has withdrawn the fee schedule as first presented, and now suggests that each communtiy submit its own schedule of fees which will be approved unless

the charges are exorbitant. This would seem only fair since fees vary in different sections of the country, and also in various sections of the state depending upon the size of that particular community.

Another point emphasized regarding changes by General Hawley was the fact that some hospitals were of the opinion that they should be reimbursed for services offered, i.e., space, nurses, personnel, etc. General Hawley, therefore, proposes that any hospital may submit a bill for these services which the Veterans Administration will pay.

The Advisory Committee also suggests an additional feature which they feel will be advantageous to the physicians of the Veterans Facility, and also to the physicians of the State. It is proposed that a series of conferences be planned to be held at the Veterans Facilities, these conferences to cover various specialties and discussions of subjects be carried on by physicians of both groups. It is also proposed that as large numbers of these veterans are examined throughout the State, regional clinical conferences could be held in various communities.

It is the desire, therefore, of the Advisory Committee of the State Medical Society that physicians throughout the State become interested in this very vital problem and attempt to develop in their own community a plan which will insure the veterans of prompt and efficient medical care. The Advisory Committee is at the service of any such community.

## Prosethetic and Sensory Devices

1. The Veterans' Administration will take over on January 1, 1946 all of the development and research work being conducted on prosthetic and sensory devices (artificial limbs, hearing aids, dentures, etc.) by the Office of Scientific and Research Development, a wartime agency which is scheduled to go out of existence December 31. In addition, the Veterans' Administration will assume on January 1, 1946 the Army's experimental work in these fields in connection with the OSRD and the National Academy of Sciences.

2. This means that the Veterans' Administration will become the central Federal agency for all research and development work on prosthetic appliances, a step that has been advocated by some Congressional and other sources, so that all Government as well as outside agencies may benefit from the results of a unified program.

3. Arrangements are now being made with the Bureau of the Budget to transfer the existing research contracts, effective January 1, 1946, to the Veterans' Administration so that this work may be continued on an uninterrupted basis. It is estimated that the work will require $1,000,000 per year.

4. The original research and development work on artificial limbs and other prosthetic and sensory devices was initiated through a Special Committee on Prosthetic Devices, headed by Dr. Paul E. Klopsteg. It was established by the National Research Council on March 20, 1945, to conduct an intensive campaign in this field, which resulted in many excellent results. In addition to the OSRD program, the Veterans' Administration has been conducting limited experimental and development work at its hospital in the Bronx, New York.

5. It is emphasized, however, that the permanent research and development program is concerned only with the long-range future aspect of the problem. In other words, it seeks to develop the best and most modern appliances and does not include instruction as to their actual and immediate usage.

6. To meet this vital phase of the problem, the Veterans' Administration has formulated plans for an immediate research and educational program to teach the disabled veteran to properly use artificial limbs or other prosthetic and sensory appliances as quickly as possible. Leading specialists in this field will be employed to supervise the activities. A formal announcement will be made as soon as key personnel have been selected to head the program.

## Establishment of Hospitals

1. The 19 hospital locations, which General Bradley, Administrator of Veterans' Affairs, announced on October 18, 1945, are only a part of the program, and many new hospitals containing thousands of beds will be announced upon approval by the President.

2. The policy is to locate hospitals where the veterans will receive the maximum benefit from the most modern medicine and surgery of the type now available only to wealthy (or charity) patients at certain nationally known medical centers.

3. Generally speaking, the benefit received depends primarily upon the type of medicine provided and not upon the buildings housing the patients. First rate medicine can be provided only by first rate specialists.

4. There are insufficient top-flight specialists available to staff expanding Veterans' Administra-

tion hospitals. Therefore, the services of this limited number of men may be obtained on a part time basis only and only at the places where they are available, which are near the leading teaching centers. These are where the new large veterans hospitals should be located if the maximum benefits are to be provided.

5. Much of this new policy results from the number of veterans being about five times as great as before World War II. Where 4,000,000 veterans were potentially available before, there are now almost 20,000,000.

6. This requires the policy to be to bring the veterans to the hospital itself, reversing the World War I idea of bringing the hospital to the veterans.

7. This does not entail, however, the abandonment of existing hospitals or preclude the building of small local hospitals for the convenience of veterans and visiting families. It will provide a type of treatment which may well mean the difference between recovery or death for thousands of seriously ill or injured veterans.

8. The interest of the veterans themselves, rather than of communities desiring veterans hospitals required the adoption of the present policy.

As part of the program announced by General Bradley for the construction of 19 new Veterans' Administration hospitals with a total of 11,100 beds, 13 of these hospitals with 9,550 beds are located near medical schools. They are:

| LOCATION | BEDS | NEAR |
|---|---|---|
| New Haven, Conn. | 500 | Yale Medical School |
| Albany, New York | 1,000 | Albany Medical College |
| Buffalo, New York | 1,000 | University of Buffalo Medical College |
| Newark, N. J. | 1,000 | Columbia University Medical College |
| | | Long Island College of Medicine |
| | | New York Medical College |
| | | Flowers and Fifth Avenue Hospitals |
| | | New York University College of Medicine |
| | | Cornell University Medical College |
| Baltimore, Maryland | 300 | Johns Hopkins |
| Washington, D. C. | 750 | George Washington and Georgetown Medical Schools |
| Louisville, Kentucky | 750 | University of Louisville School of Medicine |
| Iowa City, Iowa | 500 | State University of Iowa College of Medicine |
| Omaha, Nebraska | 500 | University of Nebraska College of Medicine |
| | | Creighton University School of Medicine |
| New Orleans, La. | 500 | Louisiana State University School of Medicine |
| | | Tulane University of Louisana School of Medicine |
| Oklahoma City, Okla. | 1,000 | University of Oklahoma School of Medicine |
| Cincinnati, Ohio | 750 | University of Cincinnati College of Medicine |
| Gainesville, Fla. | 1,000 | University of Florida Medical School |

The October 18 list provided also for additions to 13 existing hospitals and four domiciliary facilities with a total of 4,176 new beds.

Funds for the new hospitals and additions are being requested for the current fiscal year (1946). They are part of the overall 29,100 bed program approved by President Truman on August 4, 1945. The remainder of the program, which will be announced later, will be requested for the 1947 fiscal year.

## Appointment of Drs. Magnuson and Blain

General Bradley has announced the appointment of Dr. Paul B. Magnuson of Chicago, an outstanding surgeon and orthopedic specialist, to develop the research and postgraduate training program in veterans hospitals throughout the United States. Dr. Magnuson will have charge of developing research programs for Veterans Administration in conjunction with consultants in special medical fields; formulation of training policies for medical personnel; and establishment and operation of all schools or courses of instruction on professional subjects for VA doctors.

He has announced also the appointment of Commander Daniel Blain, 47, of New York City, Public Health Service psychiatrist, as director of the Vet-

erans' Administration neuropsychiatric services. Commander Blain, who was detailed to the War Shipping Administration during the war, will have charge of the treatment of 61 per cent of the veteran patients under Veterans' Administration care. He also will supervise the establishment of mental hygiene clinics in each of the 53 Veterans' Administration regional offices.

## Hospital Care for Veterans

Arden E. Hardgrove, member, Council on Government Relations, and superintedent, Norton Memorial Infirmary, Louisville, Kentucky, speaking before the House of Delegates of the American Hospital Association at its recent meeting in Chicago called attention to the fact that the concept of government responsibility for adequate medical and hospital care of veterans of any war, even though the illness be non service connected, was initiated within a few years after World War I. For the first time confronted wtih a large number of veterans needing hospital treatment of more than a domiciliary nature and in light of the tremendous advances made by medical science in the previous years, the Federal Congress faced two decisions: The extent of hospital and medical benefits which should be granted veterans, and the method by which these benefits should be made available to the individual veteran.

Care of World War I veterans both in cviilian hospitals with government financing (initiated because veterans' hospital facilities were inadequate) and in the many Federal veterans hospitals which were subsequently built demonstrated weaknesses in both types of care. These findings, noted at some length in the report, were carefully considered by this special committee in formulating its suggestions.

Since it is felt by some organizations that veterans' care could be improved, a special committee of the American Hospital Association was appointed to analyze past experiences in the care of veterans and formulate recommendations which the Association, representing the best in administrative experience in civilian hospitals, might suggest, in order to assist in the development of a satisfactory Federal program. As a result of its study, the Veterans' committee has recommended, with the approval of the Council on Government Relations, the Committee on Coordination of Activities, and the Board of Trustees, of the American Hospital Association: That the Federal government continue responsibility for financing hospital and medical care for service-connected disabilities for all veterans, and for non service-connected disabilities when the veterans are unable to meet that expense; that insofar as possible the Federal government avoid the construction of a large number of additional general veterans' hospitals, and emphasize instead the construction, expansion and use of community hospitals, which will be equally available to the veteran, his family, and his neighbors; that the veteran have free choice of care in Federal or non Federal hospitals for treatment of short term and acute illnesses, and outpatient ambulatory care, with Federal reimbursement on an equitable basis for care of veterans in non Federal facilities; and that other stated freedoms of choice of medical and hospital care be given to veterans.

Veterans will receive more satisfactory hospital and medical care if these resolutions are adopted. At the same time the Veterans' Administration would also find it possible to concentrate on the improvement of care for the chronically ill, and to maintain a less complicated system with greater assurance of better care for the veteran.

## Postgraduate Medical Training at Columbia

The Faculty of Medicine of Columbia University and its affiliated hospitals are offering two types of training to the men returning from service. Long term, full time training of 1 to 3 years is offered at the residency level in all clinical fields. Also over 200 refresher courses are available of 1 to 8 weeks in length in every branch of medicine.

The first type of training is intended for medical officers who graduated under the accelerated program of medical education and had an abbreviated hospital training before entering military service. The other type is what is signified by its name of refresher and is intended, in some cases for general practitioners, in others only for specialists.

YOU CAN'T GO WRONG — Treatment of such common skin lesions as verrucae, angiomas, clavi, keratoses, etc., is made simple and sure with the Specialties Dry Ice Apparatus. The $CO_2$ snow, confined within tip of Specialties Applicator, is pressed against the lesion. It is as simple as that! Available at The Professional Equipment Company, 36 Howe Street, New Haven, Connecticut.




(SEE PAGE 2)

# WOMAN'S AUXILIARY

## TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President,* Mrs. James Raglan Miller, Hartford
*President-Elect,* Mrs. James Douglas Gold, Bridgeport
*First Vice-President,* Mrs. Creighton Barker, New Haven
*Second Vice-President,* Mrs. H. Bertram Lambert, Southport
*Recording Secretary,* Mrs. Charles W. Goff, West Hartford
*Corresponding Secretary,* Mrs. Edwin R. Conners, Bridgeport
*Treasurer,* Mrs. Julian G. Ely, Lyme

### Board of Directors Meeting

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held on Wednesday, October 31, at the New Haven Medical Association Library.

Reports of the activities of standing committees and of the County Auxiliary meetings were heard.

The President, Mrs. James R. Miller, announced that the Connecticut State Medical Society has invited the members of the Woman's Auxiliary to attend their dinner meeting at the New Haven Lawn Club. Mrs. Herbert Thoms, chairman of the New Haven County Hospitality Committee; Mrs. Benedict Landry, chairman of the Hartford County Hospitality Committee; and the County Auxiliary presidents: Mrs. Arthur Landry, Hartford; Mrs. James D. Gold, Fairfield; Mrs. W. B. Walker, Litchfield; Mrs. Walter N. Nelson, Middlesex; Mrs. Luther K. Musselman, New Haven; and Mrs. Ralph Gilman, Windham; will serve as hostesses. Flowers for the dinner will be arranged by a committee from the Woman's Auxiliary.

The Board voted to send a Christmas greeting card to medical officers still in Service.

The President, Mrs. Miller, suggested that we open some of our meetings to members of other clubs who might be interested in our programs. This is being done in other Auxiliaries throughout the country.

### Semi-Annual Meeting

The semi-annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society will be held on Thursday, December 13, at 3:00 P. M. at the New Haven Historical Society Building, 114 Whitney Avenue.

There will be a regular business meeting and special committee reports. The revision to the constitution will be presented at this time by Mrs. Paul Phelps, chairman of Revision Committee.

The President, Mrs. James R. Miller, will give a report of the Second Annual Conference of the State Presidents and Presidents-elect and National Chairmen of Standing Committees of the Woman's Auxiliary which meets in Chicago, December 5 and 6.

At 4:00 P. M. there will be guest speakers. Dr. James C. Fox, assistant director of the Hartford Hospital, will speak on "The Soldier Returns to Civilian Life." Dr. George Wulp, who has recently returned from a mission to Europe as a civilian member of the United States Strategic Bombing Survey, will speak on "Civilian Health in Germany."

Following the semi-annual meeting, the members of the Woman's Auxiliary are invited to attend the dinner meeting of the Connecticut State Medical Society. This is a special opportunity to hear Roger I. Lee, president of the American Medical Association, and Morris Fishbein, editor of the *Journal of the American Medical Association.*

Remember this date, Thursday, December 13, at the New Haven Historical Society Building.

### Fairfield County

The fall meeting of the Woman's Auxiliary to the Fairfield County Medical Association was held in the auditorium of the Connnecticut Power Company's Building in Stamford on October 30, Mrs. James Douglas Gold, presiding.

The secretary's and treasurer's reports were read and accepted.

George B. Garlick, president of the Fairfield County Medical Association, greeted the members and urged continual expansion of the Auxiliary. Mrs. James R. Miller, president of the Woman's Auxiliary to the State Medical Society, and Mrs. Creighton Barker, vice-president of the State Auxiliary spoke on the activities of the State and County Auxiliaries.

Reports were heard from Mrs. C. L. Fincke, chairman of the Legislative Committee; Mrs. Paul H.

Brown, chairman of the Publicity Committee; Mrs. J. Grady Booe, chairman of the Program Committee; Mrs. Francis G. Findorak, chairman of the War News Participation Committee, and Mrs. George Buckhout, chairman of the Constitution and By-Laws Committee. Mrs. Booe announced that the Spring Meeting would probably take place in April and would be a luncheon meeting in Bridgeport.

Mrs. Gold introduced Stanley B. Weld, editor-in-chief of the CONNECTICUT STATE MEDICAL JOURNAL and a member of the Council of the State Medical Society, who addressed the members on "Cancer Control."

The meeting was adjourned at 4:00 P. M. and tea was served with the Stamford members acting as hostesses.

## Hartford County

The second annual fall meeting of the Women's Auxiliary to the Hartford County Medical Association was held on October 23 at the Hartford Club. The meeting was called to order at 4:30 P. M. by Mrs. Arthur Landry, president.

The reports of the chairmen of the standing committees showed active interest in the various fields of endeavor of the organization. Mrs. Stanley Osborn, chairman of the program committee, outlined the plans for a program of speakers and exhibits to be held on February 26 and 27 at Centinel Hill Hall, G. Fox & Co. This program is to be open to the public and will be of a medical and health nature. It is to be absolutely free of charge. The war participation committee announced that it is preparing Christmas cards for the men still in service and attempting to aid returning physicians in finding suitable office locations. The membership committee reported that the organization now consists of 320 members. Plans were made to have the organization represented on a radio program in the spring. Mrs. Creighton Barker gave an interesting report on the activities of the other Connecticut county auxiliaries.

Following the business meeting Dr. Edward A. Deming extended greetings from the physicians and said they approved the program of speakers and exhibits planned for February. Dinner was served at seven. Mrs. Louis Spektor gave a delightful vocal recital accompanied on the piano by Mrs. Stanley B. Weld.

After dinner Lt. William Jameson, public relations officer, Old Farms Convalescent Hospital, Avon, discussed the work being done to rehabilitate blind soldiers. He said that the most important thing to accomplish is to build up self confidence and self reliance in the blinded men. The public can aid them by giving them the opportunity to do the work they are capable of doing. They must be accepted by the people but not waited on.

Dr. Fred Couey, the new assistant director of the Community and Veterans' Service Center just opened in Hartford, gave a very interesting outline of the work the center is doing. Its chief functions, he said, are to pool and coordinate the social agencies, to develop new resources for helping the returning veterans and to counsel them on their problems which range from how to spend their money to what job or what schooling is available for them. The meeting adjourned at 10:25 P. M.

## New London County

The Woman's Auxiliary to the New London County Medical Association held its fall meeting October 18. The members of the Woman's Auxiliary were guests of the State Farm for Women in Niantic and were taken on a tour of the Farm including the infirmary, maternity hospital, and cannery. Tea was served and a short business meeting followed.

Mrs. Alfred Labensky, president, announced the following nominating committee to present a slate of officers at the Spring meeting: Mrs. David Ward of Niantic, chairman; Mrs. Sidney Drobnes of Norwich and Mrs. Willard Morse of New London. The following committee to plan a meeting between fall and spring was also announced: Mrs. David Sussler of Norwich, chairman; Mrs. H. Peter Schatz of Colchester and Mrs. Eric Blank and Mrs. Willard Morse of New London.

Announcement was made of two important events in which the members would be interested, the lecture and discussion course in Health and Human Relations at Jennings School and a meeting in Hartford, New Horizons for Children.

Mrs. Clarence G. Thompson of Norwich, program chairman, then introduced Miss Elizabeth Munger, superintendent, and Dr. Edith McLeod, resident physician. Miss Munger gave a short history of the Farm which was opened in 1917 as both a correctional and penal institution for women over

sixteen committed by the courts for both misdemeanors and crimes. The entire work of the Farm is carried on by the women under careful supervision. They have practical training in the cannery, dairy, laundry and hospital. In 1928 the maternity hospital was added, and in 1930 the prison building.

Dr. McLeod continued with a discussion of her work as medical head of the Farm. She said the women are admitted at the infirmary and are treated as patients. Many have physical disabilities that often are related directly to their other difficulties. They are taught physical hygiene, new standards of living and health habits which improve their outlook on life.

Dr. McLeod stressed the necessity for more preventive measures which are the responsibility of the schools, the parents and society.

## Windham County

The fall meeting of the Auxiliary was held at the Russian Bear Inn in Thompson on Thursday, October 18. Mrs. Laakso of Danielson and Mrs. Bates of Woodstock were hostesses for the occasion.

Mrs. J. R. Miller of Hartford, State Auxiliary president, was our guest and Mrs. Edith Valet Cook of New Haven, our State chairman of legislation, spoke on Medical Legislation and gave us an outline of the Hill-Burton, Pepper and the Murray-Wagner-Dingell bills now pending.

# SPECIAL NOTICES

### VAN METER PRIZE AWARD BY GOITER ASSOCIATION

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association which will be held in Chicago, Illinois, in April or May 1946, providing essays of sufficient merit are presented in competion.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than Ftbruary 20, 1946. The committee, who will review the manuscripts, is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any Journal selected by the author.

### SOCIETY FOR PREVENTION OF BLINDNESS

The Annual Meeting of the National Society for the Prevention of Blindness, Inc., will be held in the Russell Sage Foundation Building, 130 East 22nd Street, New York City, Tuesday, December 11, 1945, at 4:00 P. M.

The theme of the meeting, Health Education, will be of general interest. Dr. Frederick W. Maroney, Dean, Brooklyn College, will give the principal address, *Health Education: The Importance of Eye Health and Efficiency in the Educational Program.*

### LONG ISLAND COLLEGE OF MEDICINE
### Brooklyn, New York

Announces the presentation of the Fourth Postgraduate Course in Industrial Medicine, January 14 to February 1, 1946.

Afternoon and Evening Seminars and Morning Clinics Devoted to Intensive Orientation in Industrial Medical Administration, Internal Medicine in Industry, the Occupational Diseases and Industrial Surgery.

Detailed schedules of sessions are available for distribution.

Address inquiries to: Department of Preventive Medicine and Community Health, 248 Baltic Street, Brooklyn 2, New York.

**DRIP! DRIP! DRIP!** — Doctors and surgeons everywhere are enthusiastic about the new "Dry Brow" in the operating room. It is extremely light and comfortable to wear and, rinsed out in cold water first, its cooling effect persists. Its ability to absorb nine times its own weight in perspiration assures few interruptions to wipe glasses or mop faces. Price? Seventy-five cents. (Extra utility: Some doctors use "Dry-Brow" golfing, others playing tennis.) For sale at the Professional Equipment Company, New Haven.




(SEE PAGE 2)

# OUR NEIGHBORS

## Massachusetts

According to the *New England Journal of Medicine*, Massachusetts within the near future will offer its citizens blood plasma and other blood products without cost on the same basis as serums and vaccines. The program will operate as a unit of the Division of Biologic Laboratories. The Legislature has appropriated $174,000 to equip, staff and operate a blood and blood-derivatives program. The Godfrey M. Hyams Trust, of Boston, has donated $176,000 to Harvard University for the construction of a modern, well equipped laboratory building in which processing and fractionization of blood and its products can be carried out, as well as other essential procedures.

Stephen Rushmore, M.D., has been retired as dean of the School of Medicine, Middlesex University, by vote of the trustees of the University. He is devoting himself to the practice of obstetrics and gynecology.

Because of lack of teaching personnel it would seem impossible at this time to carry out a program in Boston designed to provide refresher courses for discharged medical officers and state civilian physicians. The three medical schools and most of the teaching hospitals in Greater Boston, as well as other hospitals in Massachusetts, have signified their willingness to participate in such a program. Commenting on the situation, *The New England Journal of Medicine* says that for the time being refresher courses must be limited to short periods of intensive teaching, and cites as examples of this the program of the Massachusetts Medical Society's Post War Planning Committee and the courses of instruction at the New England Deaconess Hospital and at the Lahey Clinic.

## New York

Time Inc., publisher of *Time*, *Life*, *Fortune*, *The Architectural Forum* and *The March of Time*, has become the first organization to enroll its employees in the new plan for prepaid medical care in the home, the physician's office and the hospital recently put into effect by United Medical Service, Inc., the *Westchester Medical Buletin* informs us. Time Inc., is paying the entire cost of the service for 981 employees who are enrolled in AHS of NY and has agreed to cover any of the remainder of the employees who may in the future join the Blue Cross hospitalization plan. This publishing house has accepted the fact that 95 per cent of its staff in New York subscribed to the new plan of United Medical Service within a few days after it was announced as an indication of the way it will be received throughout that area.

*New York Medicine* informs us that the Medical Society of the County of New York has appealed to the United States Department of Commerce and also to the Regional War Plants Corporation which is in charge of the distribution of surplus materials to veterans for special consideration for medical veterans desiring to purchase automobiles. The Society's letter on this subject to the Department of Commerce called attention to the fact that a large proportion of the physicians serving with the Medical Corps in the various services are expected to be discharged within the next few months, and that an automobile is absolutely essential to the overwhelming majority of these physicians who will enter private practice.

The Society has requested these agencies to provide that discharged medical officers wishing to return to private practice be given first priority in the distribution of automobiles as against veterans entering business or professions in which the use of a car is not absolutely required.

## Medical Opinion in Rhode Island

In April of this year a questionnaire was sent to all the members of the Rhode Island Medical Society in a desire to get information concerning medical practice in that state. Among the questions were several relating to the establishment of diagnostic centers. The question was asked, "How do you look upon the establishment of one or more diagnostic centers for hospitalized patients in Rhode Island?" One hundred seventy-seven physicians answered the question—102 in favor of establishing such centers, 24 against such centers, and no opinion or doubtful 33.

Further analysis showed that what opposition there was to such clinics was almost entirely confined to men who stated that they are specialists. In commenting on the results of the questioning, the *Rhode Island Medical Journal* states:

"From the replies to the three questions the following deductions can be made. There is, in the

opinion of a representative group of Rhode Island physicians, a need for one or more diagnostic centers. This need is evidenced by the large number of patients who go to out-of-state clinics, with or without their physician's approval. The doctors of Rhode Island are strongly in favor of establishing such a center, or centers each of which should be organized by or in connection with a hospital. The need is admitted by physicians generally but apparently is felt most keenly by those in general practice. This expression of medical opinion is important and definite and may well be considered by any hospital in a position to establish and operate a first class diagnostic center as a mandate from the local profession to do so."

## Rhode Island Opens Detection Clinic

Dr. Herman C. Pitts, chairman of the Cancer Committee of the Rhode Island Medical Society, announces the opening of a Cancer Detection Clinic for Women at the Rhode Island Hospital. The Clinic is intended for semiannual physical examinations of well persons. It is free and will be open to any woman who wishes to attend. If any diseased condition is found, that individual will be referred back to her own doctor or to one of a group of men who will be designated by the Rhode Island Medical Society.

## Medicine Meets With Labor

The Council of the Pennsylvania State Medical Society, at the time the Wagner-Murray-Dingell bill was first submitted to Congress, met with seven representatives of labor organizations to discuss this bill. *The New York State Journal of Medicine,* commenting on the conference, states that the detailed discussion of the bill was "clear, factual, and complete. It strips away all pretense and shows up the bill for what it is, a scheme for political domination of medical practice in this country."

The Council on Medical Service and Public Relations of the Medical Society of the State of Pennsylvania has presented the following for labor's consideration. It has been drawn up by experts on medical care and warrants careful considertaion.

"We (the people of the United States) are spending hundreds of billions of dollars to win a war so that we may retain freedom. The inevitable tax burden will test the will and resourcefulness of many generations. If, in addition to the cost of the war, we thoughtlessly add more billions of expenditures in an attempt to buy a socialized Utopia, it might well be the final straw needed to break the financial solvency of the country. In that event, we would have destroyed all hope of security, along with freedom. We would indeed have taken an irrevocable step.

"We, therefore, submit for your thoughtful consideration:

"1. The practicing physician (your family doctor) has only one responsibility—your health and the health of your family.

"2. To make him the pawn of a huge political bureaucracy is to invite the downfall of good medical service.

"3. To regiment the doctor is to regiment the home. This is is not democracy, but totalitarianism.

"4. We ask that you join hands with us in working out the economic problems of medical service and health in an orderly fashion that will insure—

(*a*) Freedom of relationship between patient and doctor.

(*b*) Continued improvement in medical service.

(*c*) A medical profession that will continue to attract to it men worthy of the finest American medical tradition and worthy of your confidence. A politically dominated profession will not be attractive to men of highest integrity."

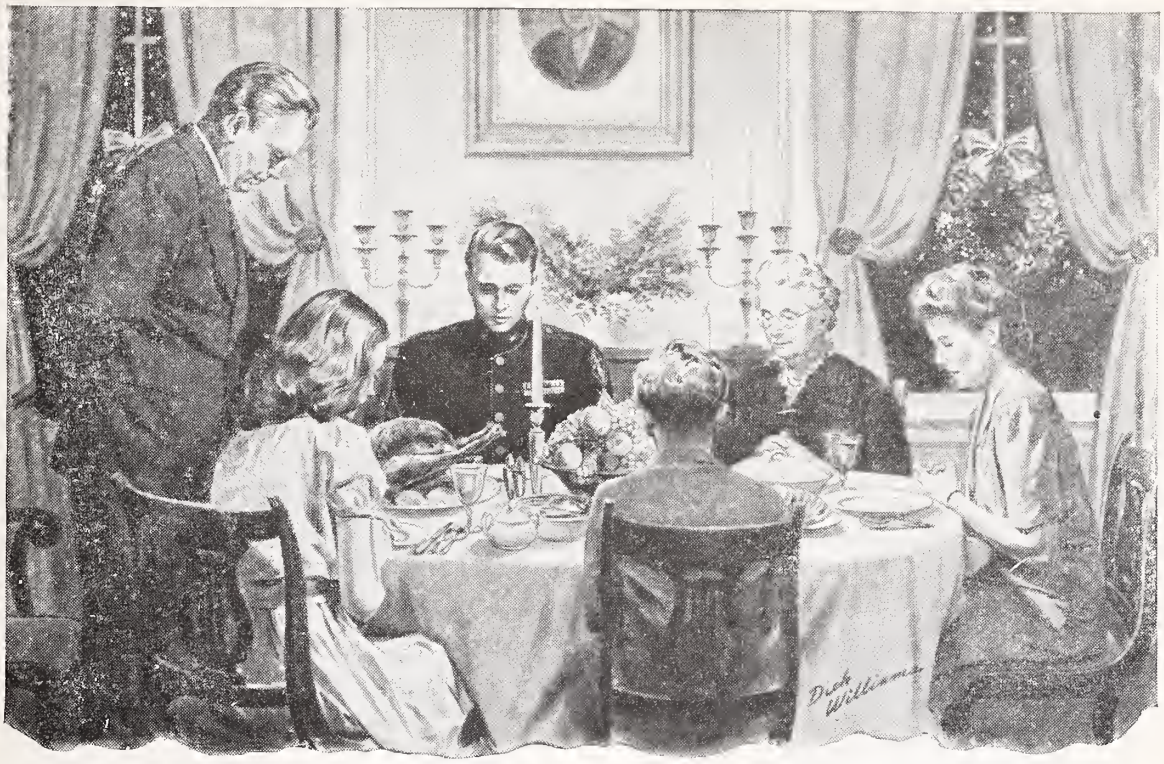
# NEWS
## *from County Associations*

### Fairfield

The annual meeting of the Norwalk Medical Society was held at the Shore and Country Club on October 11. The officers of the previous year were all re-elected. They are as follows: Louis A. Giuliano, president; Donald Corridon, vice-president; Alan Ross, secretary; Thomas Cody, treasurer.

### Hartford

The 153rd semi-annual meeting of the Hartford County Medical Association convened in Hartford on October 23. The principal matter of business was the election of Benjamin B. Robbins of Bristol as vice-president to serve the unexpired term of Aaron P. Pratt who resigned because of ill health. A




## What's the other thing we ought to do this Christmas?

For the last four years, the Christmas phrase "Peace on earth, good will to man" has had a pretty hollow, bitter ring.

This year, it won't.

And surely, one thing each of us will want to do this Christmas is to give thanks that peace has finally come to us—both peace—and victory.

One other thing we ought to do:

In our giving, this year, let's choose—first—the kind of gift that helped to bring us peace and victory and will now help us to enjoy them.

★

Victory Bonds take care of the men who fought for us—provide money to heal them, to give them a fresh start in the country they saved.

Victory Bonds help to insure a sound, prosperous country for us all to live and work in.

Victory Bonds mean protection in emergencies—and extra cash for things we want to do ten years from now.

★

Choose—first—the finest gift in all the world, this Christmas.

Give Victory Bonds!

## Give the finest gift of all – VICTORY BONDS!

representative of the Connecticut Veterans Reemployment and Advisory Committee outlined the accomplishments and future plans of that organization in their work for the returned veteran. Fifteen new members were elected to the Association.

Dinner at the Hartford Club was featured by filet mignon and butter, two rare delicacies for many a moon in the Capitol City. President Edward A. Deming presented two guests from the State Medical Society, the president, Joseph H. Howard, of Bridgeport, and the secretary, Creighton Barker of New Haven. Each had a message of interest and importance. Climaxing the evening's program was Major W. Holbrook Lowell, recently discharged from the Army. His glowing account of experiences in the China-Burma-India theatre produced mixed feelings of envy and pride among the audience. No one wished he might have been present on one of those trains crawling into the hills of Assam at the speed of 4 to 6 miles an hour in a temperature of 115° Fahrenheit. The tale of rescue of the occupants of crashed planes, of the medical care of the those valient members of our Air Force in the foothills of the Himalayas—all were woven into a glowing first hand account of intense interest. About one hundred ten members were on hand, including several recently discharged from the Armed Forces.

## New Haven

Captain Oscar Roth, AUS, of New Haven, is in charge of the cardiology section and electrocardiography department at the Regional Hosptial, Camp Polk, Louisiana.

On October 15, the Board of Directors of the New Haven and Grace Hospitals officially combined. Both hospitals are operating as separate units but the Board of Directors has been brought into one group.

The physicians in the New Haven district are returning very fast from military service and already Frederick Wies has opened his offices for the practice of ophthalmology. Louis N. Claiborn will open his offices for the practice of surgery; Courtney C. Bishop is reopening his office for surgery. John H. Bumstead, Michael D'Amico, Joseph D'Esopo are other members of the Yale Unit who are home and about ready to reopen their offices.

Mr. James Hamilton, director of the New Haven Hospital has resigned and will devote his time as hospital consultant. His company will be known as James Hamilton and Associates.

G. E. Lindskog is planning to return to his old post at the Yale Medical School by January 1, 1946.

## New London

The final program for the Wartime Graduate Medical Meetings which has carried on a program at the U. S. Submarine Base, New London, took place on Thursday, November 15. The program was a most attractive one on "Fractures of Extremities and Pelvis; Joint Fractures." In the past these meetings have been most instructive and helpful and the Connecticut physicians are to be congratulated for their effort to present the latest in medicine and surgery.

Captain Walter Lukoski, AUS, was discharged about ten days ago after serving over 3 years in the Armed Forces, in England and France. He will take some postgraduate work in orthopedics before resuming his practice. Norwich welcomes him home.

## Tolland

Captain William Schneider, who has been in military service for over three years, has been notified that he is to be released from the service soon. Capt. Schneider practiced in Rockville for several years before entering the Army, and plans to return to Rockville.

Major Francis H. Burke of Rockville spent a ten days furlough at home, on his return from the South Pacific.

Dr. J. O. Squillante has opened an office on Elm Street in Rockville. Dr. Squillante graduated from the University of Maryland and interned in the Danbury Hospital before entering the United States Army, in which he reached the rank of Captain before his discharge.

## Windham County

Willimantic has 3 men returned to town from the Services. (1) Major Sidney Vernon, long a prisoner of the Japanese, who is on leave prior to discharge and who expects to resume practice as soon as he is discharged. (2) Lt. Col. E. J. Ottenheimer has also been discharged from the service and shortly expects to resume practice. (3) Major R. E. Shea, home on sick leave from the Far Pacific, while enjoying his leave at home, died suddenly and untimely.

Dr. J. A. Woodworth, also recently discharged from the Service, has opened an office for general practice in Moosup.

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# NEW BOOKS IN REVIEW

*MEN UNDER STRESS: By Roy R. Grinker*, Lt. Col., M.C., Army Air Forces; formerly Fellow of the Rockefeller Foundation and Chairman of the Department of Neuropsychiatry, Michael Reese Hospital, Chicago; and *Major John P. Spiegel*, M.C., Army Air Forces, formerly of the Department of Psychiatry, Michael Reese Hospital, Chicago. *Philadelphia: The Blakiston Company*. 1945. 484 pp. $5.00.

Reviewed by C. C. BURLINGAME

From the observations and experience of medical officers in this war are coming many useful lessons for civilian medicine. In the field of psychiatry, the contributions of Colonel Grinker and Major Spiegel have been of exceptional interest. The present volume, *Men under Stress*, continues the high standard of their previous publications, notably *War Neuroses in North Africa*, a monograph published last year. This book contains a wealth of clinical observation on Air Forces personnel, together with therapeutic data and psychodynamic formulations which carry implications for the psychiatry of civilian life.

The authors have seen several thousand casualties in the combat theatre or hospitalized in this country, and from these they have selected 65 pertinent case histories which they present in conjunction with the various problems discussed throughout the text. The reactions to combat are examined from several standpoints, with particular reference to the amount of stress precipitating breakdown. The authors signal out two arbitrary groups, in one of which the stress has been minimal and yet has led to severe symptoms, while in the other the stress has been severe and has only produced marked symptoms after prolonged exposure. The crucial factor would seem to be, in their opinion, the initial psychological preparedness of the individual to react to specific stimuli. They explain the regressive failures of adaptation underlying combat reactions in terms of ego dynamics and in terms of cortico-diencephalic interrelations.

In dealing with reactions after combat, an interesting distinction is drawn between the overseas cases and the returnees to this country. In the latter, the pattern of behavior resulting from stress becomes obviously linked to the precombat personality and previous manner of solving conflicts. The authors elaborate on this phenomenon and attempt to segregate the underlying patterns of behavior into various groupings such as passive-dependent states, guilt and depression, aggressive and hostile reactions, and psychotic-like states.

A number of chapters deal with treatment—the techniques of psychotherapy, narcosynthesis, and adjunctive pharmacological measures. These are of particular significance from the point of view of short-term therapeutic procedures.

*Men under Stress* was a recent Basic Book selection in the series sponsored by Psychosomatic Medicine. Psychiatrists and others concerned with the emotional problems of their fellows are finding it interesting and rewarding reading.

*CLINICAL BIOCHEMISTRY:* (Third edition, Revised.) *By Abraham Cantarow*, M.D., Professor of Physiological Chemistry, Jefferson Medical College; formerly Associate Professor of Medicine, Jefferson Medical College, and Assistant Physician, Jefferson Hospital; and *Max Trumper*, PH.D., Lt. Commander, H(S) USNR, Naval Medical Research Institute, National Naval Medical Center, Bethesda, Md.; formerly in charge of the Laboratories of Biochemistry of the Jefferson Medical College and Hospital. 647 pp. with 29 illustrations. *Philadelphia and London: W. B. Saunders Company*. 1945. $6.50.

Reviewed by ABRAHAM WHITE

The developments in biochemistry during the past five years have necessitated the revision of the previous edition of this book which appeared in 1939. The combined efforts of a clinician and a biochemist have prepared a volume which emphasizes the application of biochemistry to clinical medicine and surgery by interpreting the clinical meaning of biochemical findings. The extensive supplementation and revision of the material presented in the last edition is evidenced by the list of topics which are now included as major additions in the present work. However, the treatment of some of these is very brief. The new topics are: the intravenous glucose tolerance test; modern views regarding ketosis; abnormal serum globulin reactions; creatine tolerance test; acid phosphatase in prostatic malignancy; serum organic iodine in thyroid disease; intermediate metabolism of iron; tests for adrenal hypofunction and hyperfunction; sulfur metabolism; inulin, diodrast and hypuran clearance studies in the evaluation of glomerular and tubular function and renal blood flow; blood galactose in the galactose tolerance test; colloidal gold, cephalincholesterol and plasma prothrombin tests of hepatic function; porphyrin metabolism; quantitative studies of direct-reacting serum bilirubin; classifications of jaundice; present views regarding the physiology of gastric and pancreatic secretion; secretin test in the study of pancreatic function; serum amylase and lipase in acute pancreatitis; methods for study of deficiency in vitamin A, thiamine, riboflavin, nicotinic acid, ascorbic acid and vitamin K. A new chapter on "Hormone Assay and Endocrine Function" has also been added. The final chapter of the book is entitled "Outline of Chemical Abnormalities in Various Disorders" and presents a list of biochemical alterations seen in a variety of diseases, with a reference to the page on which each particular alteration is considered.

This volume, like the previous editions, should occupy a useful place in the library of the practicing physician, the clinical investigator, and the teacher of biochemistry.

*TREATMENT IN GENERAL PRACTICE:* (Fifth Edition, Reset.) *By Harry Beckman*, M.D., Professor of Pharmacology, Marquette University, School of Medicine, Milwaukee, Wisconsin. 1070 pp., illustrated. *Philadelphia and London: W. B. Saunders Company*. 1945. $10.00.

Reviewed by JOHN C. ROWLEY

In this revision, the author has more than maintained the high standard of excellence which has made his book so outstanding and so highly esteemed.

The revision has been thorough, the most recent advances



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Paul Rand

in the use of the newer sulfonamides, penicillin and other drugs, are well covered and new sections have been added without materially enlarging the size of the volume. This has been possible not by eliminating any essential subject matter but by judicial condensation and abridgement of those portions given over to the discussion of controversial subjects or opinions.

The following are a few of the twenty-five entities that have been added: Air-sickness, blast syndrome, chemical burns, Rh factor syndrome, sub-clinical deficiency states, hypoprothrombinemia—all selected and presented with the author's fine judgment.

Dr. Beckman is to be congratulated and physicians and medical students will be pleased at his success in making one of the very best books on treatment still better.

*ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1944. Chicago: American Medical Association.* 1945. Cloth. Pp. 238. $1.00.

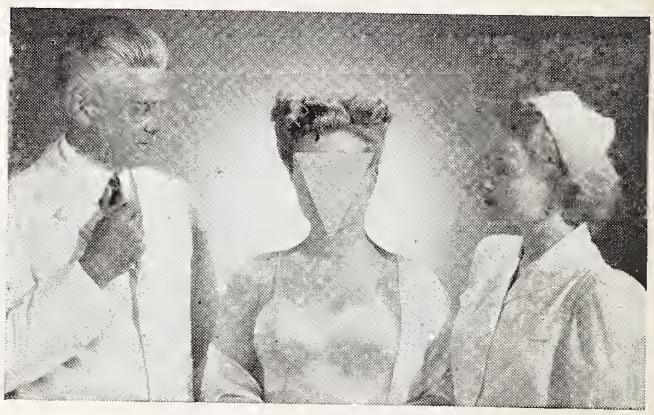
The Council on Pharmacy and Chemistry recently issued the thirty-sixth edition of the Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association. This volume contains in compact form not only the reports of the Council which have been published in *The Journal* during the past year but also some additional reports which were not considered of sufficient importance to be published in *The Journal.*

The present volume is quite unusual in that it contains not one report concerning a product found unacceptable. However, there are five reports on the omission of products from New and Nonofficial Remedies, mainly for the reason that they have outlived their usefulness, and in most cases the manufacturers have expressed their lack of desire for continued inclusion of their brands. These reports are: Erysipelas Streptococcus Antitoxin and Antierysipelas Serum Omitted from New and Nonofficial Remedies; Ichthammol Preparations, Isarol, Ichthynat, Ichthyol, Omitted from New and Nonofficial Remedies and Soluble Ichthammol, Not Within the scope of New and Nonofficial Remedies; Iodine Compounds: Iodalbin and Stearodine; Iodo-Casein; Iothion; and Iodostarine, Omitted from New and Nonofficial Remedies; Mercuric Oxycyanide, Mercuric Salicylate and Mercuric Succinimide Omitted from New and Nonofficial Remedies and Status of Antimeningococcic Serum and Meningococcus Antitoxin.

This volume is a veritable mine of information on subjects of general interest to the physician, pharmacist and the pharmaceutical manufacture. The reports concern deliberations of the Council on general subjects ranging from the use of the Electron Microscope to the appraisal of new drugs. The report on Pathogenic Bacteria, Rickettsias and Viruses as shown by the Electron Microscope is noteworthy as being pioneer work in this field. The report on the Current Status of Prophylaxis by Hemophilus Pertussis Vaccine was prefatory to the accepance by the Council on various brands of pertussis vaccines and pertussis vaccine combinations. The valuable and highly informative article on Local Treatment of Thermal Cutaneous Burns reports on the latest and best work in this field.


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*NEW AND NONOFFICIAL REMEDIES, 1945*, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1945. *Chicago: American Medical Association.* 1945. Cloth. pp. 760. $1.50.

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January first is published in book form under the title of "New and Nonofficial Remedies." The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary mixtures if they have originality or other important qualities, important nonproprietary nonofficial articles, simple pharmaceutical preparations, and other articles which require retention in the book.

Some fifteen or twenty newly accepted preparations appear in the 1945 volume. A large number of preparations have been omitted, mainly brands of official preparations. The general statement concerning these pharmacopeial preparations has been retained for the information of physicians.

As stated in the preface, the entire book has been scanned to bring it up to date with the latest medical knowledge. It is noted that the section "Articles and Brands Accepted by the Council But Not described in N.N.R.," a vestigial remnant of which appeared in the 1944 volume, has now entirely disappeared.

This section appeared to have been a catch-all for brands of official articles the acceptance of which the manufacturers desired for reasons of prestige, and miscellaneous preparations which were not necessarily or importantly within the Council's scope and which did not require detailed description. Many of the official preparations have been transferred to the body of the book and the others deleted. One is struck by the large amount of medical information contained in this volume. Certainly no other compendium of comparable price contains so much.

*A TEXTBOOK OF SURGERY*. (Sixth edition.) *By John Homans*, M.D., Clinical Professor of Surgery, Emeritus. Compiled from lectures and other writings of members of the surgical department of the Harvard Medical School. With a Special Bibliographical Index and with illustrations by Willard C. Shepard and others. *Springfield, Ill.: Charles C. Thomas.* 1945. 1,278 pp. $8.00.

Reviewed by N. William Wawro

This popular surgical text is now presented in its sixth edition with 188 pages of new material added since its last revision five years ago. To those familiar with the earlier editions, the arrangement of the introductory historical sketch followed by pertinent anatomical and physiological data is preserved in each chapter. Relevant gross pathology is correlated with symptoms and differential diagnosis. Treatment is dealt with in general terms with brief mention of the various procedures applicable and their expected end results. Illustrations of anatomical, pathological and clinical data are numerous and of a high standard. A rather complete bibliography is appended.

The various sub specialties of surgery are covered, including anesthesia and plastic surgery. Chapters devoted to fractures and peripheral vascular disease are, for practical purposes, monographs of rare excellence. New material includes mention of thiouracil in treatment of hyperthyroidism; use of the hemostatic agent, fibrin foam, in abdominal and neurosurgery; and use of various new antibiotics in treatment of surgical infection. Key references to recent surgical literature are singled out, viz., cervical fascial infections, treatment of lung abscess, etc. Experiences derived from war surgery are discussed with reference to immersion foot, "blast" syndrome, treatment of shock, delayed closure of wounds, etc.

To make the fundamentals of surgery so readable, and to bring this material up to date requires rare talent. This revision should enhance the popularity of the text. This reviewer unreservedly recommends this book.

*NEW DIRECTIONS IN PSYCHOLOGY: Toward Individual Happiness and Social Progress. By Samuel Lowy*, M.D. *New York: Emerson Books, Inc.* 1945. $3.00.

Reviewed by Stanley B. Weld

It is not surprising to find a book of this nature written by a European and published at the close of the world's most devastating war. We are told that the volume is based mainly on lectures delivered by the author ten to fifteen years ago in Bratislava, Slovakia, and especially on two lectures delivered more recently in Manchester, England, in which country the author has been residing during the greater part of the recent war.

The author's theme is the development of State control, "a control of all spheres absolutely essential to a high level of well-being of the citizen." It is not Communism as we understand it today, but the development of individual security for the masses, those "who are still very human, and potentially very estimable specimens of the genus homo sapiens." Such people who have not inherited rank and prestige when placed in a more favorable environment could become more distinguished and more productive, according to Dr. Lowy.

The writer is a reformer. The interesting fact brought out in this book is his manner of reform. He explains the need for social psychology in the world today. He describes the conflicts between man and man, between parents and their


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**Our service to the profession was greatly impaired with 14 of our staff in the armed forces. However, the return of these men and the increasing availability of medical supplies and equipment will enable us to render continously improving service from now on. Your patience and co-operation during the war years is sincerely appreciated.**

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children, and between government and citizen. And then by a process, not of an even distribution of means, but rather of a more even distribution of burdens and of pains, he portrays the type of State controlled community he would establish where voluntary fairness of the individual is not taken for granted but a better planned social process develops this fairness of spirit in all inter-human relations.

It is a philosophy of life which one would expect as a reaction from the individual-destroying rule of the Nazis. It is idealistic and yet, as the author states, people "could be deceived again, kept in ignorance and in unawareness of what could be done for them and for all of us," but is it just and human and does it pay to prevent what is going to materialize some day from transpiring earlier?

The book is dry and tiresome where the author expresses himself in the phraseology of psychoanalytical and academic psychology. The closing chapters well repay the reader for toiling through to the end. The pattern of social reform would interest all thinking individuals who strive for a solution to the world's present ills and the prevention of future wars.

*A MANUAL OF SURGICAL ANATOMY.* Prepared under the Auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council. *By Tom Jones* and *W. C. Shepard. Philadelphia: W. B. Saunders Company.* 1945. 254 pp. $3.00.

Reviewed by N. William Wawro

This latest and last volume of Military Surgical Manuals, just released by the Committee on Surgery of the National Research Council, is devoted to surgical anatomy. It is a pocket-type of handbook measuring but 5½ x 8 inches with a flexible cloth cover, well bound and printed on excellent paper. It bids fair to become a standard text occupying a permanent place in the library of medical students, house officers, surgeons and even medical librarians.

There are 139 pages of anatomical plates covering the entire body derived from many sources including standard anatomical and surgical texts, surgical monographs and journals in addition to drawings from actual cadaver dissections by two outstanding medical artists, Mr. Tom Jones and W. C. Shepard. Some plates are done in color. The standard incisions, with the exposure afforded, are illustrated.

In addition, there is an explanatory index of 114 pages listing both standard English nad B.N.A. terms where anatomical titles differ. The origin, insertion and innervation of all muscles is described. The branches and anastomoses of arteries and veins is concisely stated, and the anatomical relations of viscera and bones is given.

The compactness, clarity and completeness of this work will provoke popular appeal among students and surgeons. The reviewer's only criticism is that this volume was not made available sooner.

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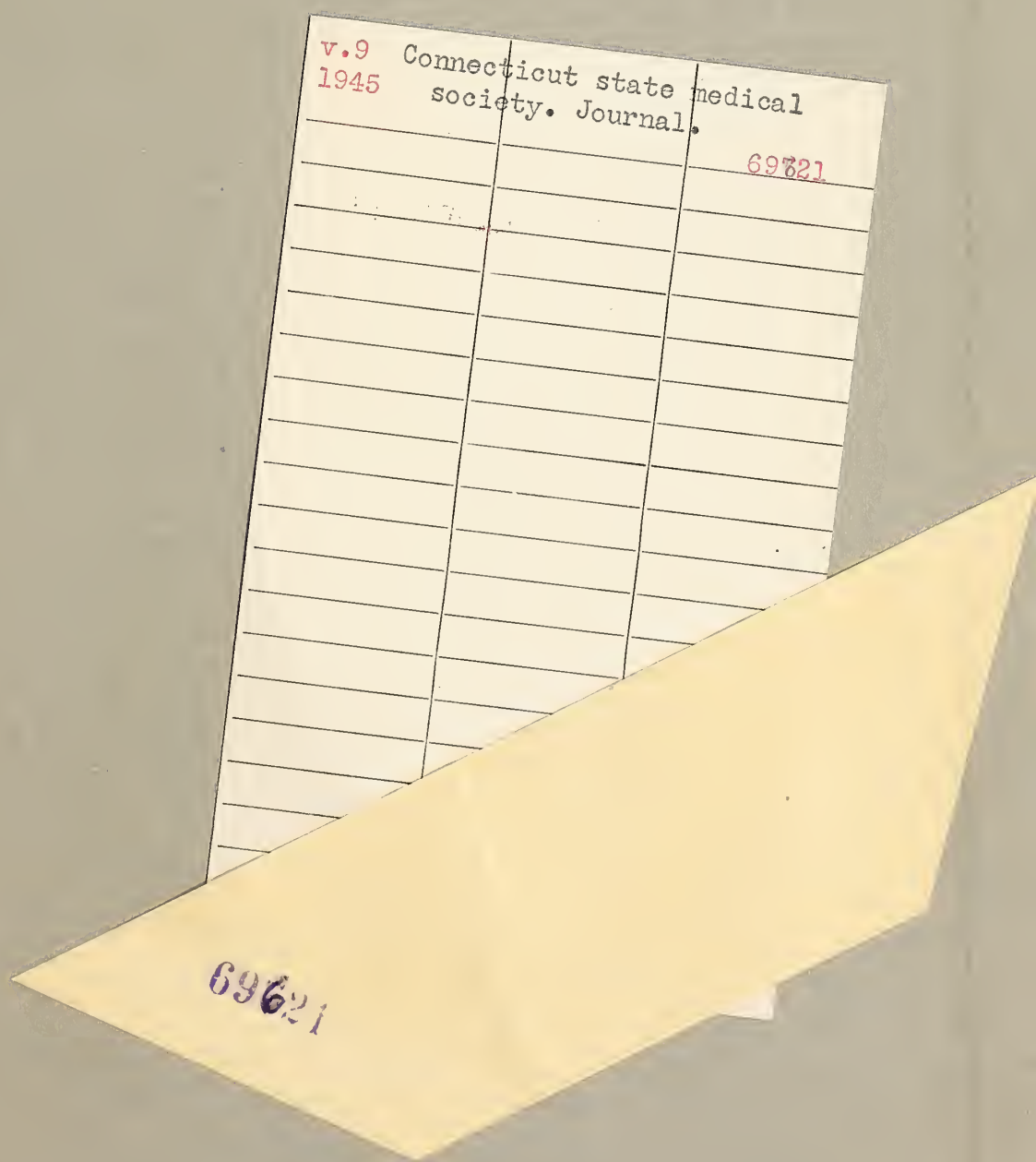
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